

THE STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

2003 COMMUNITY COLLABORATIVE
ANNUAL STATUS REPORT



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EXECUTIVE SUMMARY

"[Community Collaborative] members have to view the collaborative as being of value; [we] need strong leadership, a consistent structure and [a] shared vision with others." – 2003 Respondent to the "Community Collaborative Member Survey" discussing their view of the barriers collaboratives face.

"[I] get more of a sense of what communities and families are struggling with; I become more effective helping those I work with." - 2003 Respondent to the "Community Collaborative Member Survey" on why they participate in their local Community Collaborative

"Because we believe in the concept of [the] System of Care; that children can be better served when they and their families are listened to and they receive services they feel they need, not the services professionals think they need." - 2003 Group Response to the "Community Collaborative Member Survey" on why they participate in their local Community Collaborative

This sixth edition of the annual System of Care Status Report outlines the progress that the State's twenty-seven (27) Community Collaboratives have made over the past year. It also provides information about the crucial next steps these consortiums must undertake to strengthen their individual infrastructures by building on and enhancing the existing strengths within each collaborative.

Parents, Family Advocates, Care Coordinators, and other members from all 27 Community Collaborative's were asked to complete a "Community Collaborative Member Survey" that detailed the functioning, progress and areas of improvement for each local Community Collaborative. Each collaborative was asked to submit 6 surveys; one hundred forty-five (145) were returned. Responses were combined with other information, including observations of the collaboratives made by the DCF Statewide System of Care Coordinator and feedback generated through 2 Technical Assistance Workshops held in May and June of this year.

Care Coordination

Care Coordination data for the period of July 1, 2002 –June 30, 2003 reveals the following:

- 710 children received care coordination services. The capacity now exists to serve approximately 1200 children per year. The demand for care coordination far exceeded the supply in 2002-2003. Survey respondents suggest that upwards of 770 referrals for the Systems of Care were received during SFY 2003
- 159 of 266 children placed on a waitlist for Care Coordination due to unavailability of Care Coordination at the time of referral.
- 70% are boys and the average age is 11.7 years and;
- 50.4% are Caucasian/White, 13.9% are Black (African-American and West Indies Islanders), and 17.7% are Puerto-Rican, and 8.3% are Multi-Racial;
- 76% live with one or both biological parents.
- 62% of the children served have no current DCF involvement. Referrals for children in Voluntary Services accounted for 14% of all referrals, while referrals of children in Protective Services and Committed Statuses (abuse, neglect, uncared for) comprised 10.8% and 2.7%, respectively.

Referral Sources for Care Coordination

- 23% (161) by DCF;
- 2% (20) through the legal system (Juvenile Justice);
- 9% (67) by schools;
- 18% (128) by parents/self;
- 10% (70) by the Child Guidance Clinics;
- 27% of the remaining bulk of referrals were made by:

- Hospitals (26); Residential Treatment Facilities (10); Emergency Mobile Psychiatric Services (EMS) (21); Extended Day Treatment Programs (9); Partial Hospital Programs (26); Private Providers (14); Social Service Agencies (56); Youth Service Bureaus (12); Local Systems of Care (14).

Stronger linkages with the juvenile justice system will be critical to serving those youth in the justice system with severe mental health needs; 122 children served during SFY 2003 currently had - or were at significant risk for - criminal involvement yet only 20 (or 2%) of the 710 youth served in Care Coordination in SFY 2003 were referred by juvenile justice personnel. The importance of partnering with schools to create effective programming for the children receiving services through the Community Collaboratives is evidenced by 48% of the children being identified as Special Education involved and that 25% of the cases identify problems in school as the rationale for the referral.

Family Advocacy

During FFY 2003, FAVOR and its member associations served 3,665 parents. The Family Advocates employed by FAVOR provided direct service to over 300 families. This is a decrease over last year, but reflects deliberate and concerted efforts to align the Family Advocacy program with the receipt of Level III Care Coordination.

Community Linkages

All of the collaboratives reported the need to continue to recruit participation from schools, police, juvenile justice, clergy, recreation programs, housing, and the private sector. An increase in school personnel attending the collaboratives and participating in Child Specific Team Meetings was reported but these results are localized and appear to be dependent on a number of factors, including but not limited to, the length of time a Collaborative has been "in existence" to the ability of the collaborative's members to "convince" a school system of the benefits of being part of the Community Collaborative. More Collaboratives developed committees that are designated to initiate outreach for broader membership, while those who had developed these sub-committees in the past reported on their efforts to engage these groups.

Quality of Relationships

The Relationship Between Parents and Traditional Service Providers

Care Coordinators and other providers rated the quality of this relationship more poorly than the parents that responded. The lower average score from Family Advocates may suggest that they (the advocates) are being informed of difficulties in these relationships from the families with whom they are working (who are not "members" of the collaboratives). Parents who see themselves as "members" of the Collaboratives may be having more positive experiences and interactions with providers through the activities of the Collaboratives. An identified, though underutilized strength or power of the collaborative process is the provision of a vehicle for "open and honest communication." Since many respondents identified this relationship as already having a "good base," utilizing this power more frequently could significantly enhance these key relationships.

The Relationships Between Parents and Non-Traditional Service Providers and Between Traditional and Non-Traditional Service Providers

The respondents identified the following on a consistent basis to improve these relationships:

1. Increase the number of non-traditional providers who attend the collaboratives by reaching out to them. For example:
 - Demonstrate to them how participating in the collaborative could help them.
 - More interactions would help improve relationships and service delivery.
2. Encourage all providers to have a greater understanding of and respect for, the help each other can provide to children and families when their services are integrated. For example:
 - Acknowledge that non-traditional service providers can fill loopholes and obstacles in traditional therapy.
 - An increased awareness will help them see how they 'fit' together to serve families.
 - Reduce the rigid expectations of what and how services should be provided.
3. Increase the capacity of non-traditional service providers (especially community based recreation, respite, and after school/weekend youth group programs) to work with SED children and reimburse them accordingly.

The Relationship Between the Community Collaboratives and the Communities They Serve

The ideas generated to improve this relationship fell into 2 broad areas: Outreach and Funding. Outreach would focus on (1) raising awareness by educating members of various groups in the community (clergy, civic groups, local businesses, parents, all types of service providers) about the Community Collaboratives' mission, goals and function which would lead to (2) recruiting members of these diverse groups to become active and committed members of the collaboratives. Funding would be to pay for the collaboratives outreach efforts and administrative support and to develop and expand services (both formal and informal) that would be available to children and families and the larger community. Frustration about the limited availability of services was listed as a prominent reason that many people over the years have either dropped out of the collaboratives or resisted coming in the first place.

The Relationship Between the Community Collaboratives and DCF

A large number of respondents across disciplines suggested the re-establishment of the Regional Systems of Care Coordinators and/or the Community Serves Units as a critical step toward improving collaboratives' relationships with DCF. Others suggested that minimally, the identification of a consistent regional staff liaison with knowledge of the System of Care Model and localized services and structures to attend collaborative meetings would be sufficient. Collaborative members believe The Department's presence is necessary to clarify, operationally define, and implement various concepts in the Community Collaborative Practice Standards, as well as provide ongoing technical assistance regarding infrastructure development. Others indicated *too much* DCF presence and oversight would hinder the collaboratives' ability to manage their system and system's resources at the local level (consistent with System of Care Core Values and Principles).

Cultural Competence

The cultural competency issues with which each Collaborative struggles continue to vary between communities (e.g., outreach, membership, transportation, staff, translation services, programming, etc.). As in previous years, there is no direct evidence of exclusionary practices and all systems express interest in serving all cultural and ethnic groups in their area and extending Community Collaborative membership to diverse populations. Data from monthly Care Coordination reporting indicates that during SFY 2003, the Care Coordination caseload was 50.4% Caucasians, 13.9% African American, 17.7% Hispanic and 8.3% Multiracial. Every collaborative identified the importance of cultural competence in effective planning, service development and care management. Broadening diverse representation was frequently identified as a significant focus of strategic planning for the next year.

Overall Functioning of the Community Collaborative

The average ratings for this question were generally higher than the ratings given for each of the previous questions. Respondents appear to be having a better than average (if a rating of "5" is taken to be average) experience participating in the collaborative despite the need to improve some of the key areas that were previously rated. There was a vast range of ideas generated to improve the day-to-day functioning of the collaboratives, many of which were repeated by members of different collaboratives. The most frequently addressed included:

- Increasing the diversity of membership (both culturally/ethnically and across disciplines);
- Clarifying the structural elements of the "ideal" collaborative;
- Respecting all members' opinions and ideas to improve the Children's Mental Health System;
- Creating meaningful participation opportunities for parents and other members;
- Expanding services, creating new services and improving the quality of existing services, and;
- Increasing and/or providing financial support for the coordination and administration of meetings, agendas, minutes, and recruitment.

BEST PRACTICES

Community Collaboratives continue to engage in creative practices to supplement the current service continuum for children with complex behavioral health needs and their families. The Status Report surveys reveal that the vast majority of Collaboratives have adopted activities that exemplify the best qualities of a community approach and interagency coordination. Over forty (40) "Best Practices" were identified in SFY 2003.

Future Directions/Overcoming Barriers

There were a number of consistent themes presented in the Status Report Surveys that spoke to the barriers and challenges the collaboratives are facing. Some of the barriers identified were:

- Defining Community Collaborative membership versus participation
- Supporting greater Parent involvement at all levels of the system
- Ensuring consistent attendance at the CRC level
- Increasing the commitment levels of members to practice in new and creative ways
- Facilitating greater Collaborative membership by non-traditional providers (e.g., housing, community-action agencies, and early childhood agencies.)
- Operationally defining and implementing elements of the Practice Standards
- Creating sustainable cultural competence agendas

Potential solutions to these barriers included:

- Creating and adopting bylaws to define membership, roles, responsibilities, etc;
- Creating and following annual Work Plans that define yearly goals and objectives;
- Conducting annual needs assessments to identify gaps in services and to generate solutions at the community level;
- Utilizing core agendas at meetings to stay on task and improve the group's productivity;
- Increasing leadership opportunities for parents, non-traditional providers and informal support network members;
- Identifying and accessing funding for Community Collaborative Support Staff Positions;
- Providing "Peer Technical Assistance" and Cross-Collaborative Team Building opportunities;
- Developing mechanisms for "Peer and Self-Fidelity Assessment" processes, and;
- Creating individualized and statewide Social Marketing Plans for the Community Collaboratives.

INTRODUCTION

The Department of Children and Families (DCF or the Department), in conjunction with the Children's Behavioral Health Advisory Committee (CBHAC), conducts an annual assessment of Connecticut's local Community Collaboratives. The tool used for this assessment, a Community Collaborative Member Survey, with mostly open-ended questions reflects updates based upon the evolution of the Connecticut Community KidCare initiative (KidCare) and the System of Care approach to revamp the children's behavioral health service delivery system.

Parents, Family Advocates, Care Coordinators, and other members from all the Community Collaboratives' Community Resource Committees (CRC) were asked to complete the surveys, detailing the functioning, progress and areas of improvement for each local Community Collaborative. Each collaborative was asked to submit 6 surveys, for a statewide total of approximately 162 responses. One hundred forty-five (145) Community Collaborative Member Surveys/Responses were returned and analyzed to inform this report. This year's returns increased by 49 surveys over last year's receipt rate, but was still short of the hoped for number of 162 surveys. Table 1 illustrates the constellation of survey respondents.

Table 1. Survey Respondent

Type	# Respondents	%
PARENT	16	11
PROVIDER (CLINICAL OR THERAPEUTIC)	76	52
CARE COORDINATOR	23	16
FAMILY ADVOCATE	7	5
Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, Unidentified respondents	23	16
Total	145	100%

Survey responses were combined with other information, including

observations of the collaboratives made by the DCF Statewide System of Care Coordinator (who is also the author of this year's report), and feedback generated through two (2) Technical Assistance Workshops held in May and June of this year to create this sixth annual report, prepared in response to Public Acts 97-272 and 00-188. This sixth edition of the annual System of Care Status Report outlines the progress that the State's twenty-seven (27) Community Collaboratives have made over the past year. It also provides information about the crucial next steps these consortiums must undertake to strengthen their individual infrastructures by building on and enhancing the existing strengths within each collaborative. The continued growth and development of the local collaboratives will, in turn, support and strengthen the statewide infrastructure and service delivery system that has been developed under the Department of Children and Families' Connecticut Community KidCare Initiative in conjunction with the Connecticut Behavioral Health Partnership (CTBHP).

Children's Behavioral Health Advisory Committee

Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) to the State Advisory Council on Children and Families (SAC) to "promote and enhance the provision of behavioral health services for all children" in Connecticut. The CBHAC serves as the state's Children's Mental Health Planning Council as required by federal law, PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state's System of Care for children and families.

The 32-member CBHAC is comprised of the Commissioners of the Departments of Children and Families, Social Services, Protection and Advocacy, Education, Mental Health and Addiction Services, Mental Retardation, or their respective designees; two Gubernatorial appointments, six members appointed by the leadership of the General Assembly, and sixteen members appointed by the chairperson of the SAC. The membership composition of the advisory committee is designed to equitably and adequately represent parents of children who have a serious emotional disturbance. "At least fifty per cent of the members of the advisory committee shall be persons who are

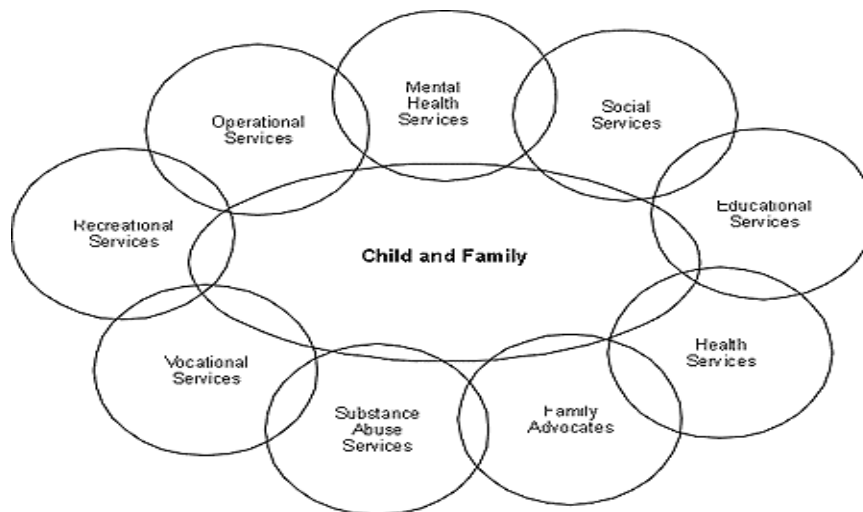
parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." In addition, a parent is to serve as co-chair of the CBHAC.

The bylaws governing the CBHAC outline their many responsibilities. In addition to the development of state's federal Children's Mental Health Plan, this committee reviews and approves all Practice Standards, including any amendments or modifications to those documents. During SFY 2001, the CBHAC approved an important change to the Practice Standards for the Systems of Care relating to the function and name of the middle tier of the Community Collaboratives. Prior to SFY 2001, the second tier of the Community Collaboratives was known as the Case Review Committee. This name, with its reference to Case Review, created tension and confusion as to the work of that committee. Many collaboratives reviewed child and family cases in front of a multiple person panel. Many of the panelists had limited or no service related involvement with the family and the process was viewed as intimidating and unpleasant for families who were asked to present before this large community empanelment.

Recognizing this blatantly "un-family friendly" practice, the work of the then Case Review Committee was revised to take-on a strong macro-community planning focus. The name of the Case Review Committee, with the approval of the CBHAC, was changed to the Community Resource Committee. During SFY 2003, the Community Collaboratives continued working to convert from a case review to a planning function. As this report will identify, most Collaboratives have done well in ensuring that child and family specific planning occurs only at the CST, and as appropriate, the Ad Hoc review team level.

A number of standing and ad hoc subcommittees are also established under CBHAC. Subcommittees related to the Community Collaboratives, include the Multiculturalism Subcommittee, The Grievance Committee, and the Care Coordination Quality Assurance Committee. These committees are responsible for developing recommendations and strategies to improve access and service through Connecticut's System of Care approach. In addition, the CBHAC serves as the Statewide Coordinated Care Committee (SCCC) in conformance with PA 97-272. Through the CBHAC's Grievance Committee, the duties of the SCCC are fulfilled. The Grievance Committee is developing standardized documents and expounding upon the existing Community Collaborative grievance procedures to ensure broad awareness and ease of understanding of the procedure for appeal.

Figure 1. System of Care Dimensions



CONNECTICUT COMMUNITY KIDCARE

In June of 1999, the Connecticut General Assembly requested that the Department of Social Services prepare a study of the financing and service delivery system for children's behavioral health. This study was in response to concerns about the bottlenecks and quality issues in children's mental health. A report to the legislature entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," identified the five major needs of the service system:

1. Better mechanisms for coordination of care;
2. Enhancing community-based resources and treatment alternatives;
3. Integrated funding;
4. Family involvement in policy as well as service planning for their own children;
5. Redistribution of resources and refinancing of the service system;

Figure 2. Key KidCare Features

Connecticut Community KidCare Key Features	
	Comprehensive health program with flexible benefit package including treatment and "wraparound" support services
	Full carve-out HUSKY child behavioral health
	Community-based and culturally competent care planning and service delivery
	Greatly expanded community-based service capacity
	Families involved and support in decision making role with strengthened family advocacy organizations
	Comprehensive training for all agency and system staff and parents
	Efficient balance of local control of care with statewide administrative support structure
	Integrated funding to support broad benefit package
	Reinvestment of increased Medicaid reimbursements
	Routine performance reports on key outcomes and quality measures.

Approximately a year later, in conformance with June Special Session Public Act 00-2, Section 5, the Department of Children and Families and the Department of Social Services (DSS) issued a report to the General Assembly entitled, *Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services*. In this plan, DCF and DSS defined the vision for the "sweeping reform of the public child behavioral health service system"¹ and in which the key features of KidCare were outlined.

KidCare is to build upon the partnerships with families, State agencies, and community providers that had been formed through the emerging System of Care Community Collaboratives. Through careful planning, training and capacity building, KidCare, using the nationally embraced System of Care model and wraparound philosophical approach, offers a blueprint for a cost effective, accountable, strength-based, family driven, culturally competent paradigm that gives families choices and help in caring for children with behavioral health challenges.

In April 2002, DSS, DCF and DMHAS issued a legislative report entitled *Connecticut Behavioral Health Partnership: Developing an Integrated System of Financing and Delivering Public Behavioral Health Services for Children and Adults in Connecticut*. This report introduced Connecticut to a newly developed system of behavioral health services designed, administered and financed by the three (3) state departments aimed at developing a comprehensive approach to behavioral health care that encompasses the life span. Key characteristics of the KidCare reform are as follows:

- Expansion and enhancement of clinical and non-clinical support services,
- A primary focus on strengthening the family's capacity to help their child with behavioral health needs; and

¹ CT Community KidCare: A Plan to Reform the Delivery and Financing of the Children's Behavioral Health Services in Connecticut: Executive Summary

- A strong preference for delivery and management of service within the local community.

KidCare further defines the reform initiative by ushering greater service quality and accountability in the children's behavioral health system through performance and outcome measurements, centralized care management, integrated data management, and comprehensive training.

The federally defined System of Care Model underlies the paradigm shift in financing and service delivery in which KidCare is founded. Like the System of Care model, KidCare is based upon a philosophy in which service planning is driven by the needs and preferences of the child and family. Both KidCare and the System of Care model provided through the Community Collaboratives seek to prevent children's problems from escalating by offering an array of flexible, individualized services that will maintain children in their homes and community. KidCare and Connecticut's Community Collaboratives espouse quality, comprehensive, community-based service provision through partnerships, interagency agreements, and key-stakeholder associations. While KidCare is the materialization of systemic service restructuring, the System of Care approach has been the solid foundation created a decade ago in which to frame the core tenets of Connecticut's reform initiative.

HISTORY OF SYSTEMS OF CARE

Nationally, the children's behavioral system has been identified as an area of concern for over 30 years. Special committees have been convened, complemented by seminal documents articulating the problems and necessary solutions to improve the quality of service to children with serious emotional disturbances (SED). During the early to mid-1980's, the vision for effective children's mental health service delivery took more complete shape. Informed by Jane Knitzer's authoring of "Unclaimed Children," which outlined the inadequacies of the nation's approach to children's mental health services, a sustained, critical review of the children's behavioral health delivery system and the role of families within that system began to occur.

Concomitant with the new focus on children's mental health, a model System of Care approach to serving children with challenging behavioral health care needs emerged. Modest federal funding became available in 1984 to launch the Child and Adolescent Service System Program (CASSP). Through CASSP, states and communities were awarded funds to develop coordinated Systems of Care for children with SED. In the 1986 monograph titled "A System of Care for Children With Severe Emotional Disturbances," authors Beth A. Stroul and Robert Friedman articulated accessible and replicable principles, values and a philosophical framework in which to "build services that would allow children with emotional disturbances to remain in their home and communities."

Three years later, the system-defining tome, "Towards a Culturally Competent System of Care Volume 1: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed" was developed. Terry Cross, Barbara J. Bazron, Karl Denis, and Maressa Issacs prepared this monograph to aid communities in effectively addressing and meeting the needs of culturally diverse children and families receiving services within the System of Care model. This document and Stroul and Friedman's publication, continue to serve as important primers in defining the conceptual matrices that form effective community-based behavioral health care for children.

From these beginnings, a nationally embraced movement to create comprehensive, coordinated, culturally – competent, interagency collaborations to effect each state's and communities' children's mental health agenda has developed. Connecticut, joining with fellow states, adopted the System of Care approach in modeling its service system for children's behavioral health. For nearly a decade, families, providers, state agencies, and other key stakeholders formed voluntary consortiums to create singular, local strategies to better serve children who have traditionally been served in restrictive, out-of-community settings. Currently, there are 27 Community Collaboratives (formerly known as Local Systems of Care) that served over 700 children during SFY 2003, using the nationally delineated System of Care model. Community Collaborative

coverage exists for every community in Connecticut. Appendix 2 lists the Connecticut towns and cities that participate in local Community Collaboratives.

THE FEDERAL AND STATE SYSTEM OF CARE MODEL

The federal Center for Mental Health Services (CMHS) defines a System of Care as follows:

A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such System of Care involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, and their families. Mechanisms for managing, coordinating, and funding services are necessary.

Under Connecticut Community KidCare, a System of Care Community Collaboratives is defined as:

A local consortium of public and private health care providers, parents and guardians of children with behavioral health needs and service and education agencies that have organized to develop coordinated comprehensive community resources for children or youth with complex behavioral health service needs and their families in accordance with principles and goals of Connecticut Community KidCare.

As the above definitions note, System of Care Community Collaboratives are predicated upon diverse, non-categorical², community-based partnerships. In a System of Care, local communities provide coordinated, comprehensive services through a partnership of families, private providers, local and state agencies, and community members. These voluntary consortiums retain responsibility for service planning and assist the families and children in their geographical area. In the community of mental health professionals, there is consensus that children are best served as members of families and that families are an integral part of local communities, and central to effective service planning and delivery. It is also recognized that, when clinically appropriate, children with serious emotional disturbance are best served when treatment is local and community based. Accordingly, the System of Care is guided by a number of guiding principles:

- Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
- Children with emotional disturbances should receive services tailored to the unique needs and potential of each child and guided by an individualized service plan.
- Children should receive services in the least restrictive, most normative environment that is clinically appropriate.
- The children's families and surrogate families should participate fully in the planning and delivery of services.
- The services offered to emotionally disturbed children should be integrated. The various agencies and programs involved should be able to coordinated and their efforts.

Figure 3. System of Care Core Values

- **Child Centered:** The needs of the child and family should dictate the mix of services provided
- **Community-Based:** Managed at the community level, where services are planned and rendered
- **Culturally Competent:** Agencies and programs should respond to the cultural, racial and ethnic differences of the populations they serve

² Building Systems of Care: A Primer – S.Pires (2002)

- Case management should be available to ensure that services are coordinated and delivered in a therapeutic manner and that children can proceed through the system in accordance with their changing needs.
- The system should promote early identification and intervention for children with emotional problems to increase the likelihood of positive outcomes.
- The system should protect the rights of emotionally disturbed children and should promote effective advocacy for them.
- Children should receive services without regard to race, religion, national origin, gender, physical disability, or other defining characteristic. Services should be sensitive and responsive to cultural differences and special needs.

The children who reach the Community Collaboratives have serious, complex, and challenging problems, typically recognized as requiring intensive, “Level III Care Coordination.”³ While the local Community Collaboratives have taken creative approaches to problem solving, and agencies with funding for fixed categories of services have shown flexibility, the children and their families often have unique needs that defy existing service formats. These children and their families require a broad menu of services—a wraparound model—tailored to suit their individual needs.

Wraparound and Flexible Funding

The term “wraparound” denotes “a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes” (SAMHSA, 1999, p. 173). The “framing elements” of the wraparound process, as set forth by the Center for Effective Collaboration and Practice (CECP) are as follows:

1. Wraparound efforts must be based in the community
2. Services and supports must be individualized to meet the needs of children and families
3. The process must be culturally competent and build on the unique values, preferences, [and] strengths of children and families
4. Parents must be included in every level of development of the process
5. Agencies must have access to flexible, non-categorical funding
6. The process must be implemented on an inter-agency basis and be owned by the larger community
7. Wraparound plans must include a balance of formal services and informal community and family resources
8. Services must be unconditional. If the needs of the child and family change, the child and family are not to be rejected from services. Instead, the services must be changed.
9. Outcomes must be measured.

The wraparound approach has proven effective in apparently intractable situations where there seemed to be no alternative to expensive out-of-home and community placement. (Burns & Goldman, 1999; VanDenBerg & Grealish, 1996) As the above elemental tenets evidence, in order for the wraparound approach to be actualized, participants must have access to discretionary funds. These discretionary funds, commonly referred to as “flexible funds,” allow for creative, strength-based, culturally competent, cost-efficient alternatives to placement. This alternative care includes services such as in-home supports, additional respite for family members, mentoring, therapeutic recreation, tutoring and behavioral coaching.

³ Pursuant to the Practice Standards for the Systems of Care, there are three levels of care coordination. Children who receive the full services of the Community Collaboratives, specifically intensive Care Coordination and Family Advocacy, are identified as being at Level III.

The KidCare initiative and the operationalization of the System of Care model, are congruent with the wraparound philosophy. Similar to wraparound, KidCare through the Collaboratives embrace the community-based treatment that occurs through a mix of clinical and complementary supports and remains cognizant of the integral role of the family within service provision. As various sections of this document evidence, the Community Collaboratives have championed the wraparound approach and have undertaken a variety of initiatives and practices to support individualized servicing for children with SED and their families. Recognizing the vital importance of the wraparound approach in creating positive outcomes for children with complex behavioral health care needs, a number of Collaboratives have independently sought funding to purchase services that complement clinical treatment and identify continued access to flexible funding as an essential need.

Presently, services within the System of Care Community Collaborative approach are funded through a variety of sources: state funded contracts, foundation grants, federal funds and insurance reimbursement. Recently, contracts have been executed with seven (7) fiduciary agencies to provide the Collaboratives with which they are affiliated flexible funding for children and their families through state Strategic Investment Board dollars. This pilot funding is critical to the Community Collaboratives and will allow them to offer a truly individualized, wraparound service approach. Funds from the Federal Mental Health Block Grant have also been earmarked to provide limited flexible funding to aid other Community Collaboratives so that they can holistically meet the needs of children with complex behavioral health care needs.

State and Federal Fiscal Year 2003 marked the first time that flexible funding was more broadly available to the Community Collaboratives. As in year's past, collaboratives sought flexible funding through private foundations and devised creative solutions to accommodate a child's individual needs. This year, many survey respondents identified the continued access to flexible, non-categorical funds as a top need of their Collaboratives.

Examples of Flexible Funds Usage Reported Outcomes, Observations and Creative Use

The following results were reported during focus groups with Care Coordinators from two Child Specific Teams that utilized the flex funding:

Children showed improvements in self-esteem, social skills, and relationships with family, other adults, and peers through the combination of services provided by an In-Home Behaviorist, a Social Mentor, and Summer Camp attendance.

- Family members reported a reduction in stress in the home environment and having more time together that was enjoyable.
- Funds used for an In-Home Behaviorist improved parenting skills for a special needs child as well as for other family members.
- Funds used for a Social Mentor improved the behavior of the child within the home and outside the home in situations ranging from school to going to restaurants, in turn easing tension in the home.
- Funds used for a camp had a twofold effect: The relationships at home between the parents and other children in the home improved with the absence of the identified child AND the identified child experienced life outside the home in an environment that was safe and nurturing. The identified child also made great gains in social skills and developed interests in art, music, etc.

Family stress was reportedly relieved through the creative use of flexible funds. Minimal funding to purchase household items such as furniture or appliances assisted in stabilizing the home environment. Families also reported feeling a sense of "normalcy" when they had access to these items. For example:

- Stress was relieved when worries about where the child(ren) were going to sleep and/or eat were not an issue;
- The home environment was improved because the acquisition of a washing machine helped eliminate some of the effects of bed-wetting or when a refrigerator was available to preserve food.

The pretest and posttest scores on the Ohio Scales showed the following on the “Problem Severity Sub Assessment Scale:”

- Parents reported an average drop of 17 points from pretest to posttest
- Workers reported an average drop of 11 points from pretest to posttest

As the surveys, national literature, and preliminary results from our own research indicate, the availability of flexible funds is an essential resource to support the Collaboratives in their mission of maintaining children with SED in their homes and communities.

In addition to creative and flexible usage of existing services, some Collaboratives have secured financial support from city governments or local educational authorities. Collaboratives have also used discretionary dollars to fund non-traditional services for clients with “special” needs that cannot be addressed by usual categorical services. Some DCF regions continue to make available small amounts of discretionary funds for System of Care clients and some Collaboratives use membership dues to create a small pool of flexible funding.

Routine access to flexible, non-categorical funds will continue to be important. While dramatic changes in Connecticut’s behavioral system have occurred to expand service access, flexible funding is a vital resource that must be readily available to all children and youth served through the Community Collaboratives. Sustainable mechanisms to accomplish this task are necessary including technical assistance and staff support to the Community Collaboratives around grant applications and fund-raising.

Connecticut Community Collaborative Structure

A local Community Collaborative (“Collaborative”) comprises one or more contiguous towns or cities holding a common vision for children’s emotional, behavioral, and educational needs. A fully operational and integrated Collaborative involves many constituents. Well-rounded Collaboratives include membership of behavioral providers, parents, schools, municipalities, state agencies, faith organizations, the business community and non-traditional agencies.

Ideally, there is a comprehensive and coordinated array of services that are implemented in conformance with the shared vision and values articulated in Connecticut’s Children’s Mental Health Plan. Members of a Community Collaborative commit their time to planning, developing and implementing the service system. Parents of children with serious emotional disturbances are involved at each level of planning and decision-making, with the needs of the child being served determining the composition of individualized, Child-Specific Teams.

As Tables 2 and 3 below indicates, the Collaboratives continued to mature and expand the constellation of participating members. Notable positive changes include:

- 26 of the 27 of the Collaboratives report that local schools systems are members – a 4% increase from last year
- 77 different school districts participated in Child Specific Team Meetings the past year
- 93% of the collaboratives report having at least one (1) parent member
- 18 collaboratives reported 2 or more parents as members
- Collaboratives reporting representation from the Juvenile Justice system increased by 21%
- There was a 28% increase in the participation of agencies specializing in substance abuse services.

Significant strides to successfully reach out to these groups have clearly been made. Similar to previous surveys, many of the respondents again identified a need to reach out to insurance companies, the medical community and non-traditional and social support services to become collaborative members. Technical assistance to tailor a message concerning the value of the participation of these groups will be helpful to these outreach efforts.

Table 2. Participation Status and Percent Change of Some Specific Service Sectors

FISCAL YEAR	Juvenile Justice	Education	Substance Abuse	Parents	Adult Mental Health	Private Insurance	Housing
SFY 2003	67%	96%	70%	93%	59%	19%	19%
SFY 2002	46%	92%	42%	79%	54%	13%	8%
Change from SFY 02 to SFY 03	21%	4%	25%	14%	5%	6%	11%

Connecticut's Community Collaboratives are expected to comply with the mandates set forth in the Practice Standards for Community Collaboratives ("Practice Standards"). These Practice Standards provide guidance to the Community Collaboratives concerning the core values and key principles of the system of care approach, and direct the general structure that each Collaborative is to have. Consistent with the guiding principle of local communities implementing the System of Care, a myriad of native forces have shaped the development of each Community Collaborative. While each Collaborative has developed and typically operates in conformance with the Practice Standards, each Collaborative's uniqueness reflects the nuances of the communities they serve. This individualization is also supported through pre-service training for the Care Coordinators, which encourages each region to tailor segments of the curriculum, particularly that pertaining to cultural competency, to capture the specific identity of the communities to be served.

System of Care Components

Connecticut's System of Care model has three, distinct structure levels that are identified in the Practice Standards:

1. Child-Specific Teams (CST), include family members, the DCF social worker (where one has been assigned), a Care Coordinator, formal and informal service providers, and a family advocate. The team is responsible for individualized care planning, the designation of a care manager, and the implementation of services. Consultation and assistance are available to the CST, as necessary from a local Ad Hoc Review Team (AHRT). The AHRT is a sub-group of the Community Resource Committee (see below).

2. Community Resource Committees (CRC) (formerly known as Case Review Committees) consist of broad community representation. The membership of the CRC should be multidisciplinary and culturally diverse in order to effectively meet the needs of children and families of the community to be served. (See Figure 4 for example of CRC membership).

Figure 4. Typical, "Mature" Collaborative Participation

- Families of children with SED
- Consumers
- Clergy
- Family Advocates
- Insurance Companies
- Care Coordinators
- DCF Systems Coordinators
- DCF RRG Representatives
- Mental Health Clinicians
- Department of Social Services Representative
- Department of Mental Retardation Representative
- Juvenile Justice
- Legal System
- Recreation

The CRC is responsible for administrative/ financial support and assistance to child-specific teams, identification of service gaps in the local system, program planning and development and identification of potential new funding sources. It reports to an Interagency Management Team.

The macro-level planning in which the CRC engages is generally informed by monthly data updates provided by the Care Coordinators. The reports provided by the Care Coordinator to the CRC are limited to aggregations of the numbers of referrals received, numbers of open cases, numbers of cases closed since last CRC meeting, and number of DCF-involved/Non-DCF involved children on the caseload. Information on pervasive barriers to services and gaps in the service array may also be provided at the CRC meeting.

Child and family specific planning occurs through the family-driven Child Specific Teams. Advisement and technical assistance may be offered to families and their Care Coordinator by convening an Ad Hoc Review Team meeting. As the name implies, the Ad Hoc team should be utilized sparingly and only on occasions when there is a firm impasse or unyielding child specific issue. The Practice Standards require that families provide written consent for the convening of an Ad Hoc team, that they (the families) can be present when the team meets and choose who is a member of the team.

3. Interagency Management Teams (IMT), include membership of parents of children with SED, family advocates, at least one mental health clinician, and high-ranking agency administrators. A “best practice” is to include representatives who provide funding at this level, as well as representatives from the Community Resource Committee. Examples are: Medicaid Managed Care Organizations or their Behavioral Health sub-contractors, the Department of Social Services, school systems, and other insurance companies, etc. Some of the IMT’s functions are to establish interagency agreements, identify local needs and barriers, create new services, assess the effectiveness of the CST’s and CRC, and most importantly, serve as a steering committee for the local community concerning children’s behavioral health services.

Memoranda of Agreement (MOA) among all participating parties on the CRC and IMT tiers of the System of Care has been identified as a component that aids in the collaborative process. More collaboratives have entered into formal agreements among their membership. Where there are no formal MOA’s in place, verbal or tacit working agreements are in place in most collaboratives so that teams can work collaboratively, productively and creatively to serve children with SED in their communities.

Child-Specific Teams

Child-Specific Teams are considered to be most effective and ideal when developed by the parents with advice from a Care Coordinator and a Family Advocate. A team is typically small, usually including clinical service providers, but should also have participation from members of the child’s extended family, clergy, and informal helpers, as well as selected professionals. The essence of the CST is that the family members being served determine those individuals that are invited to participate in the development of their child’s Individual Service Plan (ISP).

PRACTICE STANDARDS

A group representing parents of children with SED, Care Coordinators, schools, juvenile courts, child guidance clinics, and other key stakeholders spent nineteen months developing practice standards for Connecticut’s Systems of Care. The statewide Coordinating Council and the DCF Commissioner approved these standards in January 2000. The standards, which identify best practices for specific operational aspects of Systems of Care (membership, intake and assessment, criteria for closing cases, child and family rights, etc.), drew on information provided by exemplary programs throughout the country and identified the need for “one or more standardized outcome measures at all Systems of Care in the state.” In furtherance

of DCF's commitment to providing efficacious System of Care services, collaboratives must agree to follow the Practice Standards in order to receive funds to support Care Coordination services.

Revisions to the Practice Standards have occurred since 2000. A subcommittee drafted language that provided guidance on the middle tier of the Systems of Care. In the past, there was great variance in how the previously named "Case Review Committee" functioned. Over the course of a number of months, a group consisting of Care Coordinators, Family Advocates, DCF regional staff and DCF Mental Health Division Staff crafted language that more explicitly defined the roles and duties of the now named Community Resource Committee (CRC).

The Collaboratives have made significant efforts and progress in the areas of family involvement, documentation, and affirmation of families' rights. While it remains a challenge to involve parents at all levels of the System of Care, all of the Collaboratives identified the need to diligently strive for regular participation by at least one or two parents on the Community Resource and other Sub-Committees. The majority of Collaboratives have made progress over the past year in terms of their success in securing regular, meaningful parent participation at planning levels and engaging in strategies to improve family involvement. The emergence of a statewide family advocacy effort has clearly contributed to this improvement. The continued support of the collaboratives in their efforts to ensure meaningful parent and family participation at all levels of the system, both locally and statewide, will be critical to successful outcomes in this area.

Documentation is an important component of efficient service delivery within the System of Care model. The Practice Standards specify certain forms of documentation and set forth protocols for its use; the various forms include a Uniform Client Record, policies and procedures, documents granting consent, confidentiality statements, lists of collaborative members, consumer satisfaction surveys, and so forth. In the past, the documents between Community Collaboratives were very different. While all collaboratives had some type of referral form, the information collected on that document was inconsistent. Through the development of a Uniform Client Record, a standard referral form is used by all collaboratives. The family/child being referred must sign the referral form to indicate their consent before the referral is sent to the Care Coordinator and reviewed for eligibility. This seemingly simple requirement is one of the very important checks and balances designed to ensure that families' rights are safeguarded.

The Quality Assurance Committee for Care Coordination took the lead in developing standardized material for the Community Collaboratives. During SFY's 2002 and 2003, this committee created uniform Care Coordination discharge criteria, consent forms for the CST and Ad Hoc Review Teams, and release of information forms. These standardized forms assist all Collaboratives in their baseline compliance with the Practice Standards, but more importantly better ensure the integrity of the Care Coordination service and the system of care approach throughout the state.

UNIFORM CLIENT RECORD and ASSESSMENT TOOLS

In March of 2001, the Children's Behavioral Health Advisory Committee unanimously ratified the contents and use of a Uniform Client Record for the Systems of Care (UCR) and the use of two assessment tools as an amendment to the Practice Standards. An "Assessment Advisory Committee," which included direct input from Care Coordinators, Family Advocates, family members, staff of DCF and other state agencies (SDE and OPM), providers, university faculty members, and consultants, developed the UCR and selected the assessment tools over the course of a year. In addition, all Care Coordinators in the system in the 2000-2001 period had opportunities to provide input, and eight care coordinators "piloted" the UCR in the spring of 2001.

The UCR was intended to and has raised the level of professional Care Coordination practice, standardized Care Coordination across Connecticut and made the receipt of services easier for families who move within

the State and continue to require services. In particular, the UCR outlines the protocols that measure and assess client's strengths, needs, and challenges, identify functional improvement during the course of service, and identify the aspects of interventions that prove most effective with clients matching various profiles of needs, challenges, and strengths. During SFY 2002, the UCR was translated into Spanish. A finalized version of the Spanish UCR was completed in SFY 2003.

The decision to use two scales to assess children and families receiving Care Coordination through the Community Collaboratives was an important step toward identifying measurable outcomes for Care Coordination. The instruments, the *Ohio Youth Problem, Functioning and Satisfaction Scales (Ohio Scales)* and the *Behavioral and Emotional Rating Scale (BERS)*, were selected because they were viewed to be comprehensive, strengths-based assessments and consistent with the best practices endorsed in the System of Care literature. Recognizing the need for culturally competent assessments, the BERS and Ohio Scales were also chosen due to their availability in Spanish.

The Care Coordination Pre-Service Curriculum ensures that all new Care Coordinators are conversant in the values and principles of the System of Care model, taught how to properly complete the UCR, and expertly administer and score the BERS and Ohio Scales. This Pre-Service training dovetailed with the KidCare Institute Training that continued to be offered throughout the state during SFY 2003. All Care Coordinators are required to complete this pre-service training as a condition of their employment. The Pre-Service Training occurs at the local level to ensure that community specific information is woven throughout the curriculum.

CARE COORDINATION

Care Coordination, once called "Case Management," is an essential part of the system of care approach. Like Family Advocacy, Care Coordination is an integral component of effective service delivery within the System of Care model. A lack of designated Care Coordinators compromises the ability of Collaboratives to achieve identified goals thus underscoring the importance of having a full-time Care Coordinator available to all existing and developing System of Care Collaboratives. State dollars earmarked for the KidCare initiative has more than doubled the number of Care Coordinators. All towns in the state now have access to a Community Collaborative with a Care Coordinator.

Care Coordinators serve an important "quarterbacking role" in aiding families in obtaining and organizing the complement of services and supports needed to maintain children in their communities. Care Coordinators must be creative, resourceful, empathetic, trustful, and diplomatic. The challenge involves controlling the flow of information between integral players to ensure families receive seamless, non-duplicative and useful services.

Care Coordination is both a service to children and families and a sign that the system is responsive. As a service, Care Coordination is carried out in Connecticut on three levels that are explained below. The term "Care Coordinator" is associated with Level III Care Coordination, and is reserved for children and youth with the greatest need. At this level, there is extensive work with each family to assess their unique situation and to develop and implement a family driven service plan.

Care Coordination involves direct family and child contact by someone who has clinical knowledge but who does not act as a clinician for the family. The Care Coordinator develops the service plan with the family, and uses clinical knowledge and awareness of community systems to broker and advocate for the services identified by the Child Specific Team in the Individual Service Plan (ISP).

The three levels of Care Coordination reflect varying levels of need on the part of the child and the family.

- *Level I:* When a child is involved in only one service component, the child's service provider or a member of the multidisciplinary team assigned to the child is responsible for care management in partnership with the family.
- *Level II:* When a child has a DCF worker, the child's worker serves as the care coordinator collaborating with the child's primary service provider or with a member of the assigned multidisciplinary team.
- *Level III:* When a child is involved with several agencies and is identified as needing care management independent of any particular service received, care management is performed by the DCF caseworker (if the family is involved with DCF) in conjunction with a full-time Care Coordinator provided through the Local Community Collaborative (when funds permit). Care coordinators typically work with eight to twelve families at any given time because of the level of intensity usually required for each family. The total number of families with whom a Care Coordinator works over the course of a year will vary depending on factors including, but not limited to lengths of stay, the intensity or acuity levels of the families receiving services, and the availability of other providers in the community to provide care management.

As the hallmark of a responsive system, "Care Coordination" is more broadly defined. It means that the System of Care philosophy is being utilized through the Community Collaborative and is evidenced by services that are: individualized, take family preferences into account, flexible in format, use professional and natural supports, have a tracking component to ensure implementation, and can be monitored. Care Coordination in a responsive system also promotes partnership with other institutions such as school systems, juvenile courts, and social agencies and links organizations that are or might be directly involved in the collaborative. This facilitating function may be carried out by the employed Care Coordinator or by various other members of the Collaborative who embrace the System of Care philosophy.

The contractual linkage of the Care Coordination and Emergency Mobile Services (EMS) programs has added a direct clinical element to the Care Coordination service and facilitates an improved treatment continuity and service fluidity for children who experience a psychiatric crisis and require a connection to their local Community Collaborative. For example, past data indicated that the emergency mobile service programs only marginally referred children to the Community Collaboratives. The new relationship should continue to increase the number of children who are referred for Care Coordination and may change the demographics and acuity of the youngsters who present to the Collaboratives. Scrupulous review of the Care Coordination data and its interlace with EMS data, and monitoring of provider and consumer feedback, will be important to this process.

PARENTAL INVOLVEMENT & FAMILY ADVOCACY

The emerging family movement in the past ten years has given a strong voice to families raising children with mental health needs, emotional disorders, and behavioral problems. According to *Mental Health: A Report of the Surgeon General*, "The role of families has been redefined as that of a partner in care" (SAMSHA, 1999, p. 193). The results from the federal children's mental health initiative, which funded over forty demonstration System of Care projects nationally, reveal that the most successful systems are those in which family members who have children identified as SED are treated as equal partners collaborating with administrators and providers (Osher, DeFur, Spencer, & Tosh-Denis, 1999). In describing their Family Network and Support Program, CMHS notes that "Over the past 15 years, increasing evidence . . . suggest[s] the engagement of trained and empowered family members is an essential ingredient of systems of care, and that such systems can result in increased family satisfaction for themselves as a family unit and for their children in specific."

Facilitating meaningful family involvement through the Systems of Care approach stands as a prominent concern in Connecticut, as well as nationally. The state's Community Collaboratives have progressively adopted strategies to welcome and sustain caregiver involvement on all levels of the consortium. During FFY 2003, there is clear evidence that the Collaboratives focused on establishing practices that attracted and will continue to attract families to the System of Care approach. This is a tremendous gain over previous years in which some Collaborative were struggling with the meaningful inclusion of families as full

Table 3. Parent Members on Community Collaboratives

Region	Collaborative	Average # Parents
W	Greater Norwalk System of Care/CARE Team	3
W	Stamford System of Care Collaborative/CPR	4
W	Greater Bridgeport System of Care Collaborative	3
W	Stratford System of Care	3
S	Lower Naugatuck Valley Collaborative	2
S	Family Access- Eastern Middlesex Collaborative	3
S	Valley Shore Collaborative	3
S	Middlesex System of Care	4
S	Shoreline Collaborative	3
S	Hamden/North Haven Collaborative	4
S	West Haven Collaborative	1
S	Bethany Orange Woodbridge Amity (BOWA) Collaborative	UNK
S	Meriden/Wallingford Collaborative	0
S	Milford Collaborative	1
S	New Haven Collaborative	2
S	South East Mental Health System of Care	10
N	Communities Raising Children	4
N	North Central System of Care	6
N	New Britain System of Care Collaborative	3
N	Hartford/West Hart Collaborative	9
N	Bristol Collaborative	3
N	East of the River Collaborative	2
N	Route 2 Community Collaboration	3
W	Waterbury Children's Action Council	9
W	Danbury System of Care Collaborative	2
W	NorthWest Corner System of Care	5
TOTAL-AVERAGE		3.5

partners under the System of Care model. The number of Collaboratives reporting caregivers as members of the Collaborative and/or the Community Resource Committee and the total number of parents on average per collaborative has increased since last year.

Information for SFY 2003 indicates that most Collaboratives have changed their perspective on this issue and have made solid progress in expanding their membership to include parents. Collaboratives have worked to create a welcoming climate for parents of children with SED. As noted, 93% of the reporting Collaboratives indicate that they have parent members on the CRC and/or IMT levels. In general, it appears that parents who sit on the Collaboratives are valued and respected by other members of the teams. Critical factors that must be recognized as aiding this positive change include: changes to the Practice Standards that clarified the role of the CRC, DCF's securing funding to provide families with stipends to compensate them for their participation on KidCare workgroups, the creation of FAVOR, and the continued diligence of the Family Advocates.

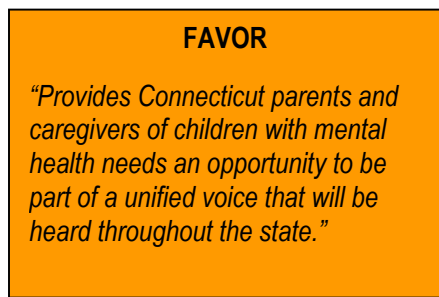
Obstacles to meaningful involvement of Connecticut's families still exist. Barriers include lack of child care, lack of transportation, inability to secure time off from work to attend regular meetings, and the inability of the Collaboratives to offer parents nominal stipends that compensate them for expenses incurred. Several systems have modified their meeting times to attract parent participation (e.g., evening) and have held special meetings at family-friendly times on a quarterly or semiannual basis. Some Collaboratives have developed Parent Advisory Groups as a further measure to garner meaningful family involvement. In addition, a number of Collaboratives received funding, particularly from the Connecticut Health Foundation, to develop initiatives that will increase opportunities for families to participate on the various levels of the service system.

Possible roles for families include advocacy at the individual and the community level, extending the reach of the funded family advocacy program; policy making and advocacy at the system level on the case review committee and/or the interagency management team; leadership of support groups; provision of selected services (e.g., respite); leadership as Collaborative facilitators or Care Coordinators; participation in evaluation, assessment, program monitoring, and outcome measurement. Families could also help educate service providers; families in Vermont, Indiana, and California teach graduate students in professional programs about raising children with serious emotional disturbances (Osher et al., 1999).

Statewide Family Advocacy Network

On October 1, 2001, the Department entered into contract with a consortium of family advocacy organizations. This contract was developed to support the development of a statewide family advocacy network to operate in partnership with families caring for children and youth with a SED. This service has been structured to emphasize empowerment, cultural competency, family strengths, parent/consumer leadership and self-determination. The network, known as FAVOR (Family Advocacy Organization for Children) is creating local outlets where families can gain skills to advocate for their children and youth and access to other, quality and responsive support. The goals of the family advocacy service are:

Figure 5. FAVOR's Charge



- To empower families through education and support such that they are enabled to take a lead role in the planning and delivery of their children's behavioral health treatment and receive the skills and encouragement required to ensure that they or their children with SED have a primary role in local and statewide activities and initiatives concerning the children's behavioral health system;
- To provide support to families who have children challenged with serious emotional disturbance;
- To share information with families that will help in identifying and accessing available services;
- To ensure family participation in treatment planning for their child;
- To advocate with public policy makers and leaders for policies, procedures laws and sufficient funding to address the needs of children with serious emotional disturbance and their families; and;
- To assist families in forming support groups in their communities.

During FFY 2002, the Department of Children and Families funded the development of a statewide Family Advocacy network. Through a consortium application that included four community advocacy organizations (i.e., Padres Abriendo Puertas, African American Parents of Children with Disabilities, Families United for Children's Mental Health and NAMI of CT), the consolidated entity known as FAVOR emerged.

FAVOR, the acronym for "Family AdVocacy ORganization for Children," identifies as its primary purpose to "foster the strengthening and expansion of the children's mental health family movement in Connecticut." It espouses the following mission:

Help improve mental health services for children with serious emotional disorders through Connecticut by increasing the availability, accessibility, cultural competence and quality of mental health services through Family Advocacy.

FAVOR Advisory Committee Agencies
Padres Abriendo Puertas (PAP)
African Caribbean American Parents of Children with Disabilities (AFCAMP)
Families United for Children's Mental Health
National Alliance of the Mentally Ill – Connecticut Chapter (NAMI-CT)

Figure 6.

FAVOR was incorporated as a non-profit agency (501-(c)(3)) during FY 2002-2003. The Executive Director of FAVOR regularly meets with the statewide FAVOR advisory committee; a committee composed of representatives of PAP, AFCAMP, Families United and NAMI-CT (see Figure 6). FAVOR continues the work initially began by the consortium of enhancing family involvement in the children's behavioral health care system. FAVOR members in various parts of the state host monthly educational forums and support groups.

The existence of FAVOR has considerably and positively advanced Connecticut's Family Advocacy movement. Through FAVOR's network, DCF funding provided stipends to the parents who participated in the Community Collaborative Technical Assistance Workshops held in May and June of this year; FAVOR and their consortium of organizations was also a co-sponsor of the workshops and provided on-site training/technical assistance to the collaboratives in attendance. In past Status Reports, strategies to foster meaningful family involvement have been articulated, but it has only been within the last two years in which the activities within the KidCare reform resonate with the commitment towards truly partnering with parents.

Family Advocates

Family Advocate positions have been dedicated to each DCF region and collaborative in the state. Parents who have navigated the service system on behalf of their own children fill these positions. These advocates are available to partner with parents as they devise their family's Individual Service Plan and support families through empathetic listening and mentoring. The advocates also help providers see problems and issues through the eyes of the family, thereby aiding in the development and provision of family friendly services.

The mission of the Family Advocates is to assist, support, inform, and provide direct advocacy to families of children with serious emotional disturbances. The Family Advocate works with individual families by providing support, education and advocacy. They participate in activities that support the inclusion of family members in the planning, decision-making, and the implementation of services to children/youth with SED. Family advocates provide technical assistance and consultation to local System of Care Community Collaboratives in the areas of family support and advocacy, sensitivity to the needs of families, and strategies to promote proactive involvement of families at all levels of the children's behavioral health system. They also assist families in the development and/or expansion of parent support groups within local communities.

The advocacy program helps fill an immense service void and helps define system needs. While volunteer advocates are necessary to ensure that all families have access to a parent experienced in finding services for a child with serious emotional disturbance, Connecticut's full-time salaried advocates are essential to the local Community Collaboratives.

During FFY 2003, FAVOR and its member associations served 3,665 parents. The Family Advocates employed by FAVOR provided direct service to approximately 243 families. This is a decrease over last year and reflects several issues:

1. Deliberate and concerted efforts to align the Family Advocacy program with the receipt of Level III Care Coordination. Previously, Family Advocacy could occur absent Care Coordination services, but under this arrangement, Family Advocates were serving in a care coordination capacity. There was not an efficient gate-keeping mechanism to regulate the Family Advocate's client load size and demand for this service - both from families receiving services through the Community Collaboratives and families outside the Collaboratives - resulted in the Family Advocates being barraged with referrals. Changes instituted the past two years have regulated some of the demand and allow the Advocates to concentrate their efforts on fewer clients. This does not however, mitigate the need for additional protocols and capacity expansion to further support the valuable work of the Family Advocates.
2. The significant increase in Care Coordinators is a salient factor that has warranted review of the practices for this service. Training is necessary for Care Coordinators and their supervisors to overcome "myths" about the true nature of family advocacy and its effectiveness when it is efficiently integrated into a family's Service Plan.
3. Turnovers in staff this past year have highlighted the difficulties in hiring for these positions. It has been a challenge to recruit and hire parents who have both the necessary skills and the time available; many are still actively dealing with the usually high needs of their child(ren) and/or families.

Activities to standardize this service and enhance the knowledge base of the Family Advocates are occurring. The Practice Standards for Family Advocacy are in development and will explicate the expectation for family advocacy and provide guidance on a number of essential aspects of this service (e.g., length of service, prioritization of referrals, etc.). The documents created by the Quality Assurance subcommittee for Care Coordination will be used as the models for the creation of a uniform referral document and standardized releases. Training opportunities for the Family Advocates and staff from FAVOR consortium members are being created under the statewide Family Advocacy network umbrella. These trainings are intended to broaden advocacy competencies and aid seasoned advocates in developing the capacity to become topical area experts. (e.g., legislative process, policy development, etc.)

INFRASTRUCTURE AND SYSTEM OF CARE APPROACH FIDELITY

System infrastructure is the organizational and procedural framework for service delivery. KidCare recognizes the important role of assessment and evaluation in determining accountability, cost consciousness, responsiveness, and the extent to which System of Care principles, such as family focus and cultural competence, are evident in Community Collaboratives' infrastructure components (e.g., governance, management and operations, the array of services offered, and quality monitoring). DCF has contracted with the Child Health and Development Institute (CHDI) in Connecticut to assist in this important endeavor. CHDI has, in turn, subcontracted with Human Services Research Institute and the Technical Assistance Center from Massachusetts to independently evaluate the KidCare initiative. This evaluation has multiple components, including: (1) an implementation analysis of system change activities; (2) an analysis of child and family outcomes; and (3) a cost-benefit analysis. A sub-study to assess Connecticut's families'

satisfaction with the System of Care approach began during SFY 2003 and will continue in SFY 2004 pending funding and advancement of the Behavioral Health Partnership. This study is designed to evaluate satisfaction with system responsiveness, perceived appropriateness of services, cultural competence of services, caregiver involvement in service decisions and outcomes of care.

Last year's report suggested that in order to assure continuous quality improvement, the state must be able to evaluate service delivery. Gauging the activities and processes by which services are provided to children with complex behavioral health care needs and their families, including the point of entry into the system, service planning, service provision, and care monitoring and review; was identified as being important to evaluating service delivery efficacy.

An independent evaluation of KidCare will be immeasurable in helping to determine true family involvement and satisfaction with Connecticut's children's behavioral health system. In addition, the role of the emerging statewide family advocacy network will critically impact the mechanisms for determining the answers to the above questions and the flavor of those answers. The KidCare evaluation has been fastidious about meaningfully involving families at all stages of this endeavor (e.g., contractor selection, evaluation planning and data collection process). Family and parent participation in the Community Collaboratives will continue to require ongoing evaluation.

Fidelity to the Model

Determining the structures and events of a given collaborative and operationally defining and implementing the Core Values and Guiding Principles of the Community Collaboratives is an incredibly complex and challenging task. The extent to which practices, activities, structures, and services of the Collaboratives adhere to characteristics of the System of Care and Wraparound approaches must be regularly assessed. A significant challenge lies in measuring the unique experiences Collaborative members have from different perspectives.

For example, a collaborative could identify having 50% (a very high number) of its "members" as parents who regularly attend the Community Resource Committee. What constitutes adherence to the System of Care Core Values, however, is the depth and meaningfulness of the parents' involvement in the collaborative (Pires, 2002). This Core Value dimension speaks less to the numbers of parents involved (although there is strength in numbers and all of the collaboratives indicated a desire to have more parents as members), and more to the depth of the relationship the involved parent feels with the collaborative, especially in terms of meaningful involvement, amount of respect they and their ideas are given, comfort level to speak freely and openly at meetings, etc. (As one parent wrote: "We don't want to be treated as token participants.") Supporting evidence of the power of the relationship comes from research on the "extra-therapeutic factors" in therapy alliances and "what works in therapy;" a key indicator of "effective therapy" is the client's perception (rating) of the depth and helpfulness of the therapy relationship he/she has with the therapist (The Institute for the Study of Therapeutic Change [ISTC] Website, 2003).

These subjective experiences are typical of the responses provided by the respondents to this year's survey when asked how the Community Collaboratives could be improved. There was a great deal of feedback on how perceptions and experiences related to the quality of the Collaboratives as well as an expressed need and desire to recruit and retain members representing diverse cultures and spheres of influence in the community (such as schools, clergy, state agencies, law enforcement, etc.). Nevertheless, the need to locate and/or develop reliable and valid standardized instruments to assess System of Care fidelity remains an important goal.

Linkages

The Collaboratives' links with the larger community directly affect family involvement, cultural competence, and continuous quality improvement. In years past, many respondents indicated that their Collaboratives represented the broader "community," yet were unable to show through broad member representation that

they actually did. Changes in attitudes, as well as more general acceptance of and adherence to the "Practice Standards," indicate there is an increased recognition of the importance of broad community representation. Most of the Collaboratives have reported concerted efforts to court and welcome new members, particularly families and non-traditional providers.

Gaps continue to exist however, and all the Collaboratives need to continue to recruit consistent participation from schools, law enforcement, juvenile justice, clergy, recreation programs, housing, and the private sector. Many of the Collaboratives reported an increase in school personnel attending Collaborative meetings and participating in Child Specific Team Meetings in this survey. These trends are localized however, and appear to be dependent on a number of factors, including but not limited to, the length of time a Collaborative has been "in existence" (many began meeting many years ago as CASSP groups), to the ability of a Collaborative's members to "convince" a school system of the benefits of being part of the Community Collaborative. Outreach to all natural sources of support for families, including the faith community and fraternal or civic organizations, remains important in creating the supportive community environment that is needed to maintain children in their homes. In addition, the failure to secure broad representation of all parts of the community can effectively defeat the guiding principles and core values of the Systems of Care. Fortunately during this past year, more of the Collaboratives developed committees designated to initiate outreach for broader membership and those who had previously developed these sub-committees reported on their continued efforts to engage these groups.

Stronger linkages with the juvenile justice system need to be established by all Collaboratives. Care Coordination data indicate that 122 children served during SFY 2003 currently had - or were at significant risk for - criminal involvement. However, only 20 (or 2%) of the 710 youth served in Care Coordination in SFY 2003 were referred by juvenile justice personnel. Studies suggest that that an "estimated 70-90 percent of [delinquent] youth suffers from mental illness, much higher than the estimated 10-20% for the non-delinquent juvenile population." (The Prevalence of Mental Health Disabilities Among Youth in the Juvenile Justice System). The overrepresentation of minorities in the juvenile justice system presents an important reminder and challenge to ensure equitable access to mental health services for African American and Latino youth.

Managed Care Organizations are service centers with which the Collaboratives want to continue to develop linkages (many respondents indicated that these organizations would be valuable members of the Collaboratives). Cost-efficient approaches taken by effective Community Collaboratives could be highly valued by managed care organizations, which want to contain the cost of behavioral health care, particularly by keeping children out of expensive, unnecessary inpatient or residential settings. Community Collaboratives could use the resources of managed care to finance creative solutions to problems that would otherwise be prohibitively expensive to treat. Some collaboratives have begun to forge alliances with health insurance organizations through their member provider agencies, but the ever-changing climate of health care options and personnel make it difficult to work toward developing service access agreements.

RESPONSES TO THIS YEAR'S SURVEY

A hallmark of the System of Care approach to community based intervention and treatment is the use of strengths based approaches to collaboration, assessment, and intervention. The intent of this year's survey was to gather information in such a way as to have respondents focus on what their Collaborative was doing well and to identify methods and/or ideas to help them move forward in substantive areas.

The use of scaling questions in this survey was designed to elicit a respondent's perception of particular areas of a Community Collaborative's functioning. For example: "On a scale of 1-10, with 10 being the best, please rate the quality of the relationship between parents and traditional [clinical or therapeutic] service providers." The respondent was then asked to give an opinion of "what would need to happen to move up at least one number on the scale." Scaling questions were developed as a tool to be used in the practice of

Solution Focused Brief Treatment (SFBT) and are used in SFBT (for both individuals and families) to elicit baseline, quantitative measures of a family or individual's perception of their presenting problem(s) (de Shazer, 1991).

The idea behind this methodology was to have respondents evaluate their Community Collaborative in “real time” and then have them begin thinking proactively about what steps could be taken to enhance the Collaborative's functioning in that particular area *from their unique point of view*. The ultimate goal, which is consistent with strengths based approaches to intervention (and particularly SFBT), is to look for the existing strengths and develop strategies for change that incorporate and enhance those existing strengths. This approach is consistent with the System of Care paradigm and eschews pathological models that search for problems, “symptoms” or weaknesses and then design strategies of change that involve a reduction of the symptom(s) and/or locating the cause of the problem.

Asking respondents to look at only assessing what would need to be done to move up one number from their initial rating (regardless of whether the rating was high or low), makes the task of making changes in the Collaborative's functioning appear more realistic and manageable (Selekman, 1997). If, for example, a rating was “2,” asking what would need to happen to achieve a “10” could make the process overwhelming and difficult to begin, leading to less motivation to effect change in the system, and perhaps dropping out of the collaborative all together.

The results of this survey also report on the status of the Community Collaboratives as a “whole;” that is, there is not an individual breakdown by Collaborative for each question. The rationale behind this approach is to obtain a “picture” of how the Collaboratives are functioning from multiple points of view (parent, provider, Care Coordinator, etc.) across the state. Responses are grouped by respondent type with averages for each question asked; recurrent ideas that were generated for strengthening areas of functioning are presented thematically.

Consistent with a strengths based perspective of intervention and change, this report will not identify Community Collaboratives by name. The Statewide System of Care Coordinator will provide specific feedback to individual Collaboratives about their members' perceptions of it's functioning in the form of individual reports.

SUBSTANTIVE AREAS OF RESPONSE

(Not all respondents chose to reply to every question asked. Four [4] Community Collaboratives responded to the survey in a group format, in which they aggregated their responses on one survey. Their scores are presented at the bottom of each chart under “GROUP RESPONSES.”)

Quality of Relationships

The Relationship Between Parents and Traditional Service Providers

1. On a scale of 1 –10, with 10 being the best, please assess the quality of the relationship between the parents and traditional (clinical or therapeutic) service providers in the collaborative.

Respondent	Average response	Range of responses (1-10)
Parent	6.9	3 -10
Provider	6.2	2 - 10
Care Coordinator	5.7	1 - 8

Family Advocate	4.9	4 - 6
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	7	3 - 10
GROUP RESPONSES	7.8	6 - 9

Proposed Solutions

Anecdotal stories and conversations with collaborative members, parents, and family advocates throughout the past year suggested that strengthening the relationships between parents and clinical providers needed additional work and attention. It is somewhat surprising that Care Coordinators and other providers rated the quality of this relationship more poorly than the parents that responded. The lower average score from Family Advocates may suggest that they (the advocates) are being informed of difficulties in these relationships from the families with whom they are working (who are not “members” of the collaboratives). It is conceivable that parents who see themselves as “members” of their Community Collaborative may be having or may have had more positive experiences with providers because of their interactions with them through the Collaboratives.

Many of the respondents – regardless of their “role” in the collaborative – identified a strength of the collaborative as providing a vehicle for “open and honest communication” (though not one that is utilized enough). These scores indicate that many members of the Collaboratives have the perception that the parent – traditional provider relationship has a good base from which to build. The majority of opinions expressed indicated a desire to build upon what is already working – again typical of SFBT (de Shazer, 1988) - or as one respondent wrote: “I think these relationships are already excellent, but there is always room for improvement.” Continuing and enhancing existing communication efforts were frequently identified as a means to improve the quality of this relationship. Many responses centered on the following themes for making improvements, including:

- Providing more information about specific services and how they may differ from each other;
- Providing opportunities for meaningful interaction between the two groups, e.g. – working on program development, policy planning, working on sub-committees, etc.;
- Improving providers’ cultural competence with respect to all populations;
- Continuing to train providers about “family centered and family driven interventions – too many providers still come off as ‘the experts’ during meetings and have trouble thinking creatively;” treat parents like experts – “value all input from all members of the family’s network as helpful; address the needs the family states they have and want help with;” this is what leads to “true” family driven, strengths-based interventions and treatment (quoted portions from clinical provider(s));
- Continuing to provide education to each other about respective roles in the Collaboratives; “on-going interaction and involvement with each other produces knowledge and breaks down barriers;”
- Continuing to be responsive to parents’ needs in terms of scheduling meetings, providing childcare, transportation, and translation services.

Last year’s Status Report author suggested that an evaluation of Connecticut’s Community Collaboratives would need to assess the extent to which family members are actively involved in the administrative and planning tiers of the System of Care model. Quantitative and qualitative data related to the following critical questions were identified as needing to be addressed: How many family members participated in System of Care policy and procedure development and in budgetary decisions? How many family members helped develop the service array or helped draft memoranda of agreement among participating agencies? Were the views of these family members respected and valued? Was their participation greater than, less than, or equal to that of other members? These are questions that clearly need to be addressed again. The necessity of re-assessing these questions is evident from two sources:

1. This year's responses indicate that collaborative members (parents as well as providers) are not satisfied with the numbers of parents who are participating; and

2. The information that collaborative members shared at the Technical Assistance Workshops held in May and June of this year (2003) (see "Technical Assistance Workshop Summary" under Collaborative Training Section) and in subsequent communications with this author, indicates that participants learned that (1) a great deal about how the creation of a sustained infra-structure is necessary for a Community Collaborative to survive and (2) fidelity to the model means involving parents in the meaningful ways as outlined above.

Many of the Collaboratives are planning extensive workshops for themselves to integrate these two principles to create new and dynamic structures that do not rely on their "old ways" of working (e.g. – only using meetings to update resources, give reports regarding numbers of children/families served, etc.). Their vision instead is to "re-create themselves" as entities where parents have meaningful participation at all levels of the collaborative and the focus of meetings is to not only share resources and report on Care Coordination numbers, but to proactively engage one another in more effective collaborative efforts and strategize new solutions to long-standing issues. It is evident from this year's survey responses that the collaboratives have embraced meaningful parent/family participation as a focus of much of their outreach efforts.

Relationship Between Parents and Non-Traditional Service Providers

2. On a scale of 1-10, with 10 being the best, please assess the quality of the relationship between the parents and non- traditional (recreation, clergy, etc.) service providers in the collaborative.

Respondent	Average response	Range of responses (1-10)
Parent	7.1	3 - 10
Provider	6.1	4 - 9
Care Coordinator	6.3	1 - 9
Family Advocate	4.4	3 - 7
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	7.3	4 - 9
GROUP RESPONSES	7.4	5 – 8.5

It is interesting again to note that parents rated the quality of these relationships as better than traditional providers, care coordinators, and family advocates. While the intent of this question was to gauge the perception of the quality of the existing relationships between parents and *non-traditional providers who were already members of and attending the Collaborative*, the ideas generated to improve these relationships provided insight into some of the issues with which most of the Collaboratives are struggling. These same issues were evident in the responses to the next question on the survey. A more complete picture can be presented by grouping these results together.

Relationship Between Traditional and Non-Traditional Service Providers

3. On a scale of 1-10, with 10 being the best, please assess the quality of the relationship between the traditional (clinical or therapeutic) providers and non- traditional (recreation, clergy, etc.) service providers in the collaborative.

Respondent	Average response	Range of responses (1-10)
Parent	6.5	3 - 10
Provider	6.1	2 - 9
Care Coordinator	5.0	1 – 9

Family Advocate	5.1	3 - 8
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	6.7	6 - 10
GROUP RESPONSES	6.9	3.5 - 9

Proposed Solutions

The solutions identified to improve these areas of the collaboratives' functioning ("Parent – Non-traditional provider" and "Traditional provider – Non-traditional provider" relationships) center around three (3) common themes. The respondents identified the following on a consistent basis to improve these relationships:

4. Increase the number of non-traditional providers who attend the Collaboratives by reaching out to them.
 - A Care Coordinator suggested that "non-traditional service providers need to have demonstrated to them how participating in the Collaborative could help them."
 - A parent suggested, "Just having more interactions would help improve relationships and service delivery."
 - Finally, consistent with building on strengths, a provider observed, "There needs to be more awareness between the two [non-traditional and traditional] services, but the relationships are excellent where [that awareness] already exists."
5. Encourage all providers to have a greater understanding of - and respect for - the help each other can provide to children and families when their services are integrated:
 - One parent noted, "Have the traditional providers acknowledge that loopholes and obstacles in traditional therapy can be filled by non-traditional service providers."
 - A Care Coordinator suggested that the two groups of providers "need to be more aware of each other as professionals [so that] their services can blend and complement each other;" or as written by a provider, "...increased awareness will help them see how they 'fit' together to serve families."
 - A clinical provider thought parents and providers "at times have rigid expectations of what and how services should be provided."
6. Increase the capacity of non-traditional service providers (especially community based recreation, respite, and after school/weekend youth group programs) to work with SED children and reimburse them accordingly. Suggestions were made to either provide training to existing programs to increase capacity or by creating new programs, especially in those areas of the state that currently lack these services. To illustrate:
 - A Family Advocate points out, "Clinical providers understand that [non-traditional] services don't work well with Level III (Seriously Emotionally Disturbed who are eligible for Care Coordination) children."
 - A provider believes that "There needs to be more space [in community activities] for referrals and more flexible hours for families."

The importance of increasing the membership of non-traditional service providers (not just recreation programs, but also members of the clergy and civic groups) is paramount to achieve a basic tenet of Wrap-around Services: "Wraparound plans must include a balance of formal services and informal community and family resources." Commitment to the Core Values and Principles of The System of Care philosophy also would be strengthened because "Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs."

An increased number of Collaboratives have made outreach to, and have regular participation from clergy, but there are still many that lack representation from this sector. Greater numbers of, and stronger connections to, faith-based organizations still need to occur; the recognition of the importance of this

happening is evidenced by the nearly unanimous identification of targeted recruitment efforts in this area for the coming year. National efforts to support faith-based initiatives may still present an excellent opportunity for Collaboratives to forge linkages with houses of worship.

The availability of these services through local Community Collaboratives, where the providers of non-traditional services have agreed to participate on Child Specific Teams and work with other members of the community, significantly increases the choices families have in creating intervention plans that are localized and have a balance of formal and informal services to address the multiple complex emotional and/or behavioral needs and challenges with which these children usually present. Clearly communicated and defined roles and mutual respect of all of the Collaborative members are integral to achieving positive outcomes for children and families.

The Community Collaborative and the Community It Serves

4. On a scale of 1-10, with 10 being the best, please assess the quality of the relationship between the collaborative (as a whole) and the community it serves.

Respondent	Average response	Range of responses (1-10)
Parent	5.9	2 - 10
Provider	5.7	1 - 10
Care Coordinator	5.5	1 - 8
Family Advocate	6.9	4 - 10
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	4.8	1 - 8
GROUP RESPONSES	6.6	4 - 9

Proposed Solutions

Overall, respondents identified the quality of the relationship (or connection) to the larger community not as high as to previously assessed areas. The ideas generated to improve this relationship fell into two (2) broad areas:

- (1) Outreach to focus on improving direct (face-to-face meetings, telephone calls) and indirect (mailings) outreach activities to the community; and
- (2) Funding to pay for the Collaboratives' outreach efforts, administrative support for the Collaboratives, and to develop and expand services (both formal and informal) that would be available to children, families and the larger community.

The purposes of the outreach activities according to most of the respondents would be to (1) raise awareness by educating members of various groups in the community (clergy, civic groups, local businesses, parents, all types of service providers) about the Community Collaboratives' mission, goals and function which would in turn lead to (2) recruiting members of these diverse groups to become active and committed members of the collaboratives.

Most of the respondents identified that their Collaboratives were already involved in active recruiting efforts through a variety of methods, including, but not limited to: mass mailings of brochures and/or informational letters; encouraging current members to recruit from their agencies (especially parents who are receiving clinical services or who are otherwise involved in the mental health system) and from collateral contacts providers may have with other services in the community; general invitations to parents to attend informational seminars; presenting information about the Collaboratives at parent support groups and through NAMI, AFCAMP, PAP, Families United for Children's Mental Health and FAVOR; posting times, dates and meeting places of the Community Collaborative on FAVOR's web-site; hosting community get-togethers like picnics and manning informational booths at local fairs.

Several of the respondents' comments indicated that some of the difficulties in attracting new members and creating stronger linkages to the community stemmed from some members (primarily those who provide clinical services) having interpretations of "who should be at the table" as too rigid and because the availability of services to the community is limited by rigid and strict clinical interpretations of service delivery. Conversely, there is also a concern within the Collaboratives that marketing campaigns could create a high demand for services, especially Care Coordination and intensive clinical services already at full capacity with waiting lists. Those who voiced this concern were clear that they were committed to the System of Care model of community based services, but did not want a situation to develop where families hopes were raised to receive services for which they would most likely have to wait.

A high number of responses *across respondent type* identified the need for continued funding for and expansion of intensive services in the community like Care Coordination, Extended Day Treatment, and Intensive In-home Therapy. Other services identified as critical to successful outcomes were respite (both in and out of home), mentoring, therapeutic recreation programs, in-home behavioral specialist services, and out-patient therapy. Others believed there was a need to provide funding directly to the Collaboratives to help with administrative support, marketing, and community organizing.

Collaborative members identified (in the survey, through personal communication, and at the Technical Assistance Workshop) frustration about the limited availability of services and believed it was a reason that many people over the years have either dropped out of the collaboratives or resisted coming in the first place. Members of the general community may not wish to attend meetings because they do not need to access services targeted toward a type of child with whom they do not usually have contact or would not be able to if they had the need because of long waiting lists. To paraphrase several respondents, "there are a lot of meetings in the community that I already have to go to...sometimes it feels as if they are duplications and choices have to be made."

The Community Collaborative and DCF

5. On a scale of 1-10, with 10 being the best, please assess the quality of the relationship between the collaborative (as a whole) and the Department of Children and Families.

Respondent	Average response	Range of responses (1-10)
Parent	7.4	5 – 10
Provider	5.7	1 - 10
Care Coordinator	4.8	1 - 9
Family Advocate	4.1	3 - 7
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	6.5	2 - 10
GROUP RESPONSES	6.6	3.5 - 10

Proposed Solutions

Changes in the DCF regional office structures within the past year provide a contextual background for the responses to this question. Prior to November of 2002, DCF had designated System of Care Coordinators (Systems Coordinators) in each of the (then) five regions. The System Coordinator was an employee of the Department of Children and Families and was available to the community and DCF staff to provide training and information on local Collaboratives and the statewide System of Care initiative. These individuals engaged in community organizing activities to help develop new, and support existing, local Community Collaboratives. The Systems Coordinators provided technical assistance to the various tiers within the System of Care model with respect to the clarification of and compliance with the Practice Standards. The Department's Statewide System of Care Program Supervisor had provided consultation and support to the regional Community Collaborative development efforts and the Regional Systems Coordinators.

Last year's fiscal challenges resulted in the streamlining of positions across the Department's organizational structure. The result of this action was that the Systems Coordinators positions, along with other positions in similar job classifications, were eliminated. This has left the Statewide System of Care Program Supervisor as the sole resource *having a position assigned with described functions relating to System of Care liaison and development* for all 27 Collaboratives. Many of the Collaboratives protested the loss of these positions directly to the Department leadership.

A large number of respondents across disciplines suggested the re-establishment of these positions as a critical step toward improving Collaboratives' relationships with DCF. Others suggested that minimally, the identification of a consistent regional staff liaison to attend collaborative meetings would be sufficient. One respondent thought that a critical characteristic of the assigned DCF staff person would be *knowledge of the System of Care Model and localized services and structures*. Responses to the survey, remarks made to this author, and discussions at collaborative meetings and the Technical Assistance Workshop, indicate that collaborative members believe The Department's presence is necessary to clarify, operationally define, and implement various concepts in the Community Collaborative Practice Standards, as well as provide ongoing technical assistance regarding infrastructure development. Other conversations with collaborative members during the course of the year however, indicated too much DCF presence and oversight would hinder the Collaboratives' ability to manage their system and system's resources at the local level (consistent with System of Care Core Values and Principles).

CULTURAL COMPETENCE

6. On a scale of 1-10, with 10 being the best, please rate the cultural competence of the collaborative as a whole.

Respondent	Average response	Range of responses (1-10)
Parent	7.2	5 – 10
Provider	5.5	1 - 9
Care Coordinator	5.3	1 - 10
Family Advocate	5.4	3 - 8
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	4.4	1 - 10
GROUP RESPONSES	5	1 - 9

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that allow all parties to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989; Isaacs & Benjamin, 1991). In keeping with national System of Care promising practices, each Community Collaborative must value diversity, be capable of cultural self-assessment, grasp the dynamics inherent in cultural interaction, have institutionalized cultural knowledge, and know how to adapt service delivery to accommodate cultural difference.

In Connecticut, cultural competence is an area that continues to pose a challenge for all Community Collaboratives. This is not to suggest that the Collaboratives are insensitive to this issue. To the contrary, many Collaboratives have again assigned importance to issues pertaining to cultural competency evidenced by the attempts and overtures they have made to attain a responsive level of service. The specific cultural competency issues that each Collaborative faces continues to vary between communities (e.g., outreach, membership, transportation, staff, translation services, programming, etc.), but all Collaboratives (and almost all of the respondents from each collaborative) appear to be cognizant of the importance of cultural competence in effective planning, service development and care management. Many Collaboratives have

engaged in activities that evidence their awareness of this issue. Many Collaboratives have created material in Spanish and are continuing to have documents translated into other community relevant languages; of those that have not done this already, it is clearly identified as a priority area and critical step in becoming more culturally competent. Others have identified resources and supports to assist families who are grappling with issues of poverty that impede positive outcomes for their child.

The emphasis on the provision of culturally competent services and outcome parity under KidCare will likely further assist the Collaboratives in this endeavor by making additional resources and technical assistance available. This is most evident through the change in staff diversity for the Care Coordination programs. Funding under KidCare has allowed many Collaboratives to hire multicultural and/or bi-lingual Care Coordinators; several respondents identified this as one of their Collaboratives' significant achievements in the past year. Increased funding and a clear emphasis on the provision of culturally responsive service through the procurement process has yielded a significant increase in the number of males, African Americans, Latinos and Spanish-speaking persons employed as Care Coordinators for the Community Collaboratives. In addition, the continued recruitment of culturally diverse Family Advocates this past year and into the next, will significantly improve the cultural competence of the Collaboratives and, most importantly, the accessibility culturally diverse families will have to family advocacy. It is likely that these improvements will facilitate greater access to the service delivery system and even better care outcomes for culturally and linguistically diverse children and their families.

As in previous years, there is no direct evidence of exclusionary practices and all systems express interest in serving all cultural and ethnic groups in their area and extending Community Collaborative membership to diverse populations. Data from monthly Care Coordination reporting indicates that during SFY 2003, the Care Coordination caseload was 50.4% Caucasians, 13.9% African American, 17.7% Hispanic and 8.3% Multiracial. These important achievements must not go unrecognized and the Collaboratives must not become complacent or fail to develop plans to increase effective service provision that is specific to other statuses (e.g., gender, age, sexual orientation, poverty, religion, etc.). In fact, every Collaborative identified the broadening of diverse representation as a significant focus in their strategic planning for development over the next year, as well as a multitude of other activities to strengthen this key component of effective practice.

While the provision of Care Coordination to the state's ethnic populations is slightly over current census percentages, it is not clear if service levels are consonant with actual need. Predictions for increases in Connecticut's African American and Latino population suggest that entities such as Community Collaboratives must develop evolving culturally responsive strategies to keep pace with needs. This is particularly important, as few Collaboratives (by their own self assessment in this area) have engaged in prominent, enduring activities to support the provision of culturally competent care. This limited engagement of cultural competence, seems to be attributable to confusion about operationalizing this complex, and multi-faceted issue.

Many Collaboratives know that equitable service outcomes are associated with cultural competence, yet few seem to fully grasp this subject and often categorize it as a race, ethnicity and language oriented matter. The need for the Collaboratives to pervasively embrace a definition of culture that is broader in focus (e.g., poverty, physical disability sexual orientation, gender, etc.) may aid in solidifying the focus and framing the necessary initiatives to achieve cultural competence. Continued training and additional resources were identified most frequently as necessary resources to improve cultural competence. These will be important contributors to operationally define a strategy for culturally responsive care.

Federal funding from the Mental Health Block Grant was earmarked specifically for this purpose. Each DCF region was given funding to work with the Collaboratives to create community endorsed work plans for achieving improvement in culturally competent service provision. During SFY 2003, the Community Collaboratives utilized funding through the Mental Health Block Grant and the CBHAC Multiculturalism Sub-

Committee to obtain items promoting and/or celebrating cultural diversity, stage multicultural community events, and bring in consultants to work with collaboratives and their member agencies. These funds are intended to facilitate the development and/or enhancement of a community specific culturally competent framework.

Nationally, there is growing demand for greater cultural competence in the Systems of Care approach. The literature identifies a confluence of factors that affect mental health service utilization rates (Sue & Sue, 1990). The cumulative impact of these factors is typically negative, with lower utilization rates for some services reported among non-Caucasian families (SAMHSA, 1999). Culturally diverse service providers are often absent from the System of Care table. The absence of broad community representation within the System of Care may contribute to underutilization and clearly undermines the development of cultural competence. A more in-depth review of whether Community Collaborative use by non-Caucasian families is disproportionately low based upon need must occur. This evaluation will need to review the interrelationship between the behavioral health needs of youth in the juvenile justice system and their access to the System of Care Community Collaboratives.

Similar to most states, Connecticut must continue to move forward with its efforts to develop culturally competent Systems of Care and a culturally responsive service array. Data suggest that when services are linked to a community's culture, higher rates of utilization, lower attrition, and improved outcomes can be expected (Sue & Sue, 1990). *The Evaluation of the Comprehensive Mental Health Services for Children and Their Families Program- Annual Report to Congress: 1999* identifies strategies to support cultural competence:

- Taskforce to address cultural competence
- Targeted outreach
- Conducting assessments of community needs related to cultural issues
- Formal cultural assessment of client populations
- Considering cultural issues in developing service array
- Creative approaches
- Training

As the above strategies identify, there is a need for multiple, ongoing dynamic approaches. Only some of these strategies have been incorporated into the structure of most Collaboratives. Mechanisms and resources to support the full integration of cultural competence into the domains of the Community Collaboratives must occur. A basic first step is to operationally define "cultural competence" through the development of indicators to guide cultural competent practice. In addition, the CBHAC Multiculturalism Subcommittee should continue to take a leadership role in identifying best practices and offering technical assistance to the Collaboratives so that they can more comfortably embrace this issue.

Activities In Which Collaboratives Engaged or Will Engage to Improve Cultural Competence

(Many of these activities were identified by multiple Collaboratives.)

- Community based cultural awareness being planned for September 2003 that includes multiple Community Collaboratives
- Direct recruitment of members from diverse backgrounds
- Training has been provided for Care Coordinators through their employing agency staff
- Training needs will be addressed at upcoming Strategic Planning event
- Program staff has conducted a needs assessment of the local community and is analyzing data
- Educational seminars have been held that are open to collaborative and community members
- Statistics were gathered on community demographics to assess prevalence of ethnic communities;

- Collaborative members attended workshops regarding cultural competence at Technical Assistance Workshops through DCF and the Connecticut Health Foundation
- Cultural Competence development identified in the Strategic Plan for upcoming year
- Direct outreach by Care Coordinators and other collaborative members was done directly to providers who primarily work with specific ethnic groups
- Spanish speaking Care Coordinators were hired
- Collaborative materials were translated into Spanish and made available to the community
- Collaborative plans to do a cultural competence self-assessment
- Discussions regarding improving cultural competence are held during collaborative and Regional Advisory Council (RAC) meetings
- Community mapping projects were begun
- Active recruitment of Haitian and Latino representatives to the collaboratives
- Actively sought Technical Assistance from PAP, AFCAMP
- Outreach to local NAACP to become a member organization
- Direct invitations to leaders of minority community were made
- Locating Care Coordinators in culturally diverse agencies in the community
- Diversity management training for Collaborative member agency Boards of Directors and Executive Directors
- Compiling a translation service list of local community to be given to collaborative members

The average ratings of this dimension of the collaboratives' functioning are predominantly in the middle of the 1 – 10 rating scale but the ranges of scores can be viewed as more accurately representing individual members' vastly differing opinions on the cultural competence of their individual collaboratives. This variability speaks volumes to the difficulty in operationally defining cultural competence and more than likely to the extreme variability of the perceptions individuals hold about meaning. There was one response in particular that was worth quoting directly even though it is "problem-oriented" in nature. This example of perceived cultural incompetence (collaborating with an organization solely to have a favorable application without incorporating the organization into the service delivery) demonstrates the importance of applying culturally competent practices to all levels of a system's functioning and not just focusing specifically on the direct practice sphere.

"The minority organizations appear to [have been] alienated by the grant process over the years. They have expressed the feeling that their organizations have not received funding. They have been requested to endorse RFP [Request For Proposal] Proposals (sic), but do not share in the grant funding."

Many of the respondents identified the need to do direct outreach to organizations that serve ethnically diverse populations. The under-representation of agencies that primarily work with ethnically diverse populations makes it difficult to assess whether these agencies do not participate because of a perception that the "larger system" continues to operate in a culturally incompetent manner or because their participation has not been valued enough.

The second most frequently proposed solution to improve the Collaboratives' cultural competence was to increase efforts to recruit culturally diverse representatives (including, but not limited to, parents, grass roots organizations, faith-based institutions and social service organizations that primarily serve specific ethnic groups) to become members of the Collaboratives. Diverse representation that includes attention to poverty, physical disability, sexual orientation, gender, etc. is an essential first step, but as some respondents accurately indicated: "just having diverse groups represented is not enough." There also needs to be the ability of the collaborative members to integrate the multitude of opinions and attitudes that stem from unique cultures, especially with respect to mental health issues, the service delivery system, and the ability to accept help (versus being labeled "resistant to treatment"). To paraphrase one respondent, some

of the agency members send representatives who are ethnically diverse, but “we have no idea if the services provided throughout that agency are culturally competent.”

Finally, there were some respondents who thought their Collaboratives were doing “o.k.” or well with respect to this issue (citing the plans to recruit and retain diverse membership) but, they also identified a key component that is often missing (and difficult to implement) for those attempting to achieve cultural competence. As one of the respondents succinctly noted, “Open and honest communication about cultural issues during our meetings would be a big help.”

The Overall Functioning of the Community Collaborative

7. On a scale of 1-10, with 10 being the best, please rate the overall functioning of the collaborative.

Respondent	Average response	Range of responses (1-10)
Parent	7.2	3 - 10
Provider	6.0	3 - 10
Care Coordinator	6.2	1 - 9
Family Advocate	7.0	3 - 10
All Others, including: Non-Traditional Providers, Municipalities, State Agency personnel, unidentified respondents.	6.3	1 - 8
GROUP RESPONSES (1 Collaborative did not provide a numerical score; rated selves as “High”)	9.0	7 - 10

Proposed Solutions

This question on the survey was intended to elicit a broad, general overview of how respondents felt their collaborative was functioning. The question itself does not define “functioning” which leaves the concept open to the respondent’s interpretation of what they were rating. Despite this, it is interesting to note that the average ratings for this question are generally higher than the ratings given for each of the previous questions. It is unknown if these differences are statistically significant, nor would any type of statistical analysis be able to be used to show significance because of the lack of adherence to any type of rigorous research protocols when the survey was designed. It may only imply that respondents are having a better than average (if a rating of “5” is taken to be average) experience participating in the collaborative despite the need to improve some of the key areas that were previously rated.

A true strengths-based approach when working with families is to assume that they are doing the best that they can right at this moment, and that they utilized some strengths (even if the family cannot identify them) to manage to get this far. Applying this same model of assessment to the Collaboratives is imperative to “following through” with the strengths-based approach. Despite the needs that respondents have identified to move forward, they are reporting functioning “better than average” with what they have at the moment.

An example of how the framing of Collaborative functioning within a strengths-based context is the following:

An interesting and unexpected outcome of the Technical Assistance Workshops this past year was the surprise expressed by the participants about how close in development they were compared to each other. It was as if each Collaborative assumed it was not doing particularly well, especially when compared to others, *even though they had little direct experience of any other Collaborative’s functioning level.* Hearing about the common challenges and successes of others was liberating for some of the participants as they no longer “felt alone” in their struggles (an interesting parallel to the success of parent support groups) because they were able to hear about the challenges other systems were experiencing or had overcome. As the groups began formulating strategic plans, they discovered many strengths on which to build, as opposed to focusing on a “litany of problems” to surmount. Challenges were clearly identified, but the discovery of inherent strengths in the

Collaborative and its members lead more quickly to achievable solutions, rather than a “laundry list” of problems. Those who attended the workshop suggested that this type of event be held on a yearly basis to encourage statewide collaboration and development.

In terms of the ideas to move ahead to improve their “functioning,” there were many expressed, many of which were common to all of the Collaboratives including, but not limited to:

- The membership needs to take responsibility for growing the collaborative infrastructure and membership
- There is a need to clarify roles, expectations, responsibilities, define directions and move to accomplish set goals
- There needs to be a greater understanding of sub- committees
- Focus on educating the larger community and each other about available resources
- Educate the members of the collaborative about its purpose and function
- More outreach “everywhere”
- Need more diversity in cultural types and representation, a larger membership in general, and more Care Coordinators to reduce waitlists
- A strong core of members already exists – increasing the number of non-traditional provider members will help– need a mixture of minds
- Be able to serve all who come quickly, especially those children with autism spectrum disorders
- Continuation of flexible funding
- Include more parents, clergy and businesses
- Increase/provide financial support for the coordination and administration of meetings, agendas, minutes, and recruitment
- Members have to view the collaborative as being of value; need strong leadership, a consistent structure and shared vision with others
- Need to understand Practice Standards and adhere to them regarding confidentiality and parent choices – cannot continue to use the old model where parents come in to a large group (10+ people) to tell their “story”
- Increase services for children with social/emotional/behavioral issues
- Improve the level of comfort in order to discuss challenging programmatic and systemic issues relating to service delivery (ability to tolerate constructive criticism)
- Continue to work at treating parents as equal partners
- Create a new member orientation packet, especially for family members – it is unreasonable to expect new people to “just catch-up” on the activities that have been going on for a long time prior to their involvement

There were also many comments made throughout the surveys about how well the Collaboratives functioned. What follows are a select few that sum up the majority of respondents’ pride in their work:

“Our overall functioning is good, but [the collaborative] has the capability and knowledge to achieve a great deal more.”

“I am pleased to be a member – the meetings are well run and we accomplish something every meeting. Associating with each other has improved the collaboration between providers.”

“This is a well developed and well attended collaborative, the attendees show a great deal of commitment.”

"This collaborative has sustained itself over a number of years and through many changes. We have a good core group of members who have the best interests of children in their mind and hearts.

"Our collaborative works great together – everyone participates and communicates with each other."

"Our collaborative functions at the top of the scale – we will need to work hard to maintain this level."

"We already have a good forum for information exchange and problem solving; we do need more community participation."

"We feel we have done an excellent job and have a high rating; the community we serve has also given us the feedback that we are thought of as a reliable and accessible resource for children and families."

DATA COLLECTION

Data collection has been an area in which the Department has infused significant resources over the past years. The advent of the Uniform Client Record (UCR) for the Systems of Care marked a watershed in the Department's data collection process. The use of this UCR and its attending monthly reporting requirements contextualized the Department's next steps in implementing a web-based data collection system for its behavioral health services. The data collection for the Care Coordination programs for the System of Care paved the way for comprehensive, client level data reporting, in which we could begin to track youth across Community Collaboratives. The new generation of reporting that the Department has embraced allows it to view children's service profiles more holistically and better support, positive individual child and family outcomes. The Department views the process in which the UCR and resulting data collection protocols were developed as solid practice.

The next important step in the data collection and management effort continues to be the dissemination process. Creating and "fine-tuning" regular, core reports that are easily understood and widely available to the community will be essential to desired service accountability and to support the Community Collaboratives in their work of identifying needs and making recommendations to improve outcomes for the children and families that they serve. Similar to the processes that were employed to secure buy-in for the data elements and collection protocols, this backend component of information management must include input from parents and providers to ensure broad utility of the data.

Care Coordination Child and Family Characteristics

Data collection has been a priority for the Department for the past several years. The Division of Mental Health has been working with providers and families to create comprehensive data collection tools to inform ongoing planning and service development. Care Coordination data for the period of July 1, 2002 –June 30, 2003 reveals the following:

- 710 children received care coordination services. With all of the contracted agencies now fully operational, the capacity will be to serve about 1200 children per year. Unfortunately, the demand for care coordination far exceeded the supply in 2002-2003. Survey responses indicated that upwards of 770 referrals for the Systems of Care were received during SFY 2003. In addition, 159 of 266 children were placed on a waitlist due to the unavailability of Care Coordination at the time of referral.
- The average age is 11.7 years and 70% are boys, which is consistent with nationwide samples of children served in Systems of Care. In terms of ethnicity, 50.4% are Caucasian/White, 13.9% are Black (African-American and West Indies Islanders), and 17.7% are Puerto-Rican, and 8.3% are Multi-Racial.
- The majority of children (76%) live with one or both biological parents.
- 48% of the children served in care coordination are in Special Education.

- 5% of the children served had juvenile justice involvement indicated by a DCF status of Dual Commitment, Committed FWSN, Non-Committed FWSN, or Delinquent/Parole Services;
- 12% (86 total) presented with “Criminal Behavior” as a Child Risk Factor.
- Seventy-six (76) of the 710 youth served were arrested in the six months prior to enrollment in care coordination.
- 62% of the children served have no current DCF involvement. Referrals for children in Voluntary Services accounted for 14% of all referrals, while referrals of children in Protective Services and Committed Statuses (abuse, neglect, uncared for) comprised 10.8% and 2.7%, respectively.
- 23% of the children presented with “Risk of Poverty” as a Child Risk Factor.

Referral Sources to the Community Collaboratives

- 23% (161) by DCF;
- 2% (20) through the legal system (Juvenile Justice);
- 9% (67) by schools;
- 18% (128) by parents/self;
- 10% (70) by the Child Guidance Clinics;
- 27% of the remaining majority of referrals were made by:
 - Hospitals (26);
 - Residential Treatment Facilities (10);
 - Emergency Mobile Psychiatric Services (EMS) (21);
 - Extended Day Treatment Programs (9);
 - Partial Hospital Programs (26);
 - Private Providers (14);
 - Social Service Agencies (56);
 - Youth Service Bureaus (12);
 - Local Systems of Care (14).

Continued programming enhancements under KidCare, such as the linkage of the EMS and Care Coordination contracts, and a greater nexus between behavioral health services and the juvenile justice system, should impact the referral sources.

This information seems to support key trends and priorities that have emerged under KidCare. For example, Family Involvement, Cultural Competency, serving Juvenile Justice populations, and cultivating partnerships with the Educational System are areas that are prominent on the KidCare agenda. As the Care Coordination data indicates, 48% of the children receiving this service are Special Education involved, and 25% of the cases identify problems in school as the rationale for the referral. Clearly, this underscores the importance of partnering with schools to create effective programming for the children receiving services through the Community Collaboratives.

The importance of family empowerment is evidenced by the fact that “Families/Self” are the second highest referral source for Care Coordination. Enhancing families’ knowledge base to successfully navigate the system will increasingly aid caregivers in identifying necessary services and supports to maintain their children in their homes and communities.

COMMUNITY COLLABORATIVE TRAINING

THE COMMUNITY COLLABORATIVE TECHNICAL ASSISTANCE WORKSHOP

The Department of Children and Families, partnering with FAVOR, The Child Health and Development Institute of Connecticut and the Connecticut Health Foundation, sponsored two, 2-day Technical Assistance Workshops for the 27 Community Collaboratives in the state. Each collaborative sent teams of four (4) people that included at least one parent of a child with a serious emotional disturbance. Each collaborative self-selected their team and identified the team members as occupying key leadership positions within their collaborative. The two days blended didactic presentations, large group facilitated discussions and small break-out work group meetings. Cliff Davis, Sheila Pires, and Kathy Lazear of The Human Service Collaborative - a nationally known organization and recognized leader in the development of Systems of Care - led the workshop.

Outcomes

1. Parents who attended the workshop received a stipend of \$150.00 per day through FAVOR.
2. Over 120 people attended the workshops and provided their contact information to DCF. This will provide the opportunity to send out information regarding practices that have worked in other parts of the state, System of Care development, educational opportunities, etc. to a large group of people committed to the KidCare philosophy and the Community Collaboratives.
3. Each team developed the framework of a strategic plan that addressed the following key concepts:
 - The expansion of the membership of the collaborative, especially with respect to parents, non-traditional service providers, and more diverse professional service systems;
 - The creation and/or enhancement of a durable management structure within each collaborative that involves parents as meaningful partners at all levels of the collaborative and that “survives” future changes in the representation of fiduciary agencies, professional services providers, etc.
 - The development of diversified financial and programmatic resources that will enhance the collaborative’s ability to sustain itself into the future.
4. Regular reports on the results of the strategic planning process and implementation of these plans are forwarded to the Statewide System of Care Coordinator. The information is included in DCF reports to local, state and federal government officials regarding the status of System of Care development in Connecticut on local, regional and statewide levels. The information will also be used to help direct future individualized technical assistance to the collaboratives.
5. Each collaborative that participated (25 of 27 total in the state) received a \$1,000.00 stipend to be used as reimbursement for expenses of professional staff or towards the implementation of the finalized strategic plan objectives.

KIDCARE TRAINING INSTITUTE

The *KidCare Training Institute* provided communities with 4-day training programs to enhance participants’ knowledge of the System of Care approach to behavioral health service delivery. Using parents, providers and DCF staff as trainers, SFY 2003 saw approximately 1,200 individuals become educated in the philosophy and tenets that are integral to KidCare. KidCare training was also made available to all DCF staff, including its top management level personnel. This important training, which was provided at no cost to participants, facilitated the broad-based service delivery paradigm shift that has been viewed as crucial to supporting the culturally competent, family driven approach that KidCare espouses. A Spanish version of this curriculum was also developed to encourage participation from Connecticut’s Latino communities.

As noted earlier, a Pre-Service Training Curriculum was developed for the Care Coordinators. Additional training opportunities were done in SFY 2003 to target not only Care Coordinators, but also Family

Advocates and other service providers. The DCF Mental Health Division, Quality Assurance Committee and the Multiculturalism Committee continue to devise training plans to more extensively address essential elements of the children's behavioral health system paradigm.

This year's survey responses again indicated a desire to have training regarding a number of different topics/issues and are indicative of the areas of improvement that the collaboratives have been identifying through their strategic planning processes, including:

- How to access certain services and benefits (e.g., HUSKY A & B)
- How to improve service quality
- Team building and meeting facilitation
- Cultural competence
- How to do [social] marketing and community outreach
- How to operate as an independent organization (Incorporation as a non-profit entity)
- Outside consultation to train people to "get on same page" as to who we are and who we serve
- Collaboration Techniques
- Recruitment strategies
- How to identify alternative resources for funding
- How to write grants to obtain funding
- Advocacy and self-advocacy
- Community in general needs more training on social/emotional/behavioral disorders and developmental disabilities
- Continuous System of Care and KidCare Training for new and current members and the community in general, especially about how to develop strong parent, school, community, business, clergy partnerships
- The roles of support services in the collaborative, community and individual families
- The use of behavior modification interventions with children as opposed to psychotropic medications
- The role of the Family Advocate
- How to do self-evaluation regarding efficacy of services and cultural competence of the collaborative and/or its member organizations
- How to engage "hard-to-engage" families
- The effects of culture on mental health issues
- Impacts of family stress on children

Training was an area that the respondents clearly identified as necessary for the on-going development and success of the Collaboratives and ultimately improve the services children and families receive through the Collaboratives and component members. Any or all of the above topics would be useful on some level for all of the Collaboratives and the communities they serve. As one respondent wrote, "System of Care service providers need more knowledge about 'family-centered philosophy;' many collaborative members and the community are not aware of the 'day-to-day' issues kids and families face."

Respondents also identified the need to share successes and ideas with other Collaboratives' members. Many expressed the belief that the interpersonal relationships that are built within, as well as across Collaboratives, are as critical to successful functioning as anything else. These respondents were in favor of more training opportunities being available for collaborative members and Care Coordinators utilizing regional and statewide forums.

SALIENT ACHIEVEMENTS

During FFY 2003, a number of successes have been realized under KidCare and through the Community Collaboratives. Individual Collaboratives and regions have engaged in numerous activities to promote and

improve behavioral health services for children and their families. A number of these achievements are listed under the Exemplary Practices section of this Status Report. Some of the additional, salient accomplishments of SFY 2003 are as follows:

- Re-Execution of Memorandum of Understanding between DCF, Department of Social Services and Department Health and Addiction Services for the purpose of the joint administration of an integrated behavioral health delivery system.
- Enhancement of parent's and caregiver's opportunities to participate in the planning and development of the state's behavioral health service reform through the provision of stipends funded through the Mental Health Block Grant. Stipends have been offered to assist families with transportation, childcare and other related expenses that have in the past hindered their ability to attend planning and service development meetings.
- Targeted Technical Assistance for 27 Community Collaboratives, offered in conjunction with the Connecticut Health Foundation, with facilitation from Sheila Pires and Cliff Davis of the Human Service Collaborative. This was a 2-day training to foster team building, cultural sensitivity and family inclusion within the administrative functions of the Collaboratives. The primary focus of this training is to help the Collaboratives develop and sustain the infrastructure necessary for success within their respective communities.
- Completion and dissemination of report for Phase One of the KidCare Evaluation
- Creation of Crisis Stabilization Beds
- Expansion of the comprehensive, client level, web-based behavioral health data collection system to include additional services
- Provision of training to Care Coordinators regarding flexible funding utilization and Individualized Service Plan development
- Release of Request for Application to support the award and development of an Administrative Service Organization.
- Creation of a Youth Suicide Prevention Informational Brochure and development of Youth Suicide Prevention Information Brochure targeted to Law Enforcement personnel.
- Funding through the Multiculturalism Sub-committee made available to the Community Collaboratives to support the promotion and development of culturally competent service delivery within the children's behavioral health service system.
- Members from the Mental Health Division present at the One-MHSIP: User Group Meeting.
- Publication of the SFY 2002, Annual System of Care Status Report
- Flexible funding allocation for Community Collaboratives to support wraparound services through the purchase of non-traditional and non-categorical services
- Development of the Educator's and Communities' Guide to KidCare
- Translation of the Uniform Client Record for care coordination into Spanish

- KidCare training provided to Probation Officers in collaboration with the Judicial Branch
- Training targeted for EMS providers
- The Greater Bridgeport System of Care Community Collaborative, in partnership with the Department and the Bridgeport Public School System awarded a Cooperative Agreement for the Comprehensive Community Mental Health Services For Children and Their Families Program. The \$9.5 million award will be used to create a school-based system of care.
- Suicide Prevention Training offered for parents, DCF staff, and providers
- Development of KidCare Workgroup to create and define a Levels of Care System for Residential Treatment Facilities. The workgroup was comprised of parents, providers, state agencies and DCF staff.
- Continued appropriation of over \$14 million, annualized, to enhance the service array within the KidCare continuum including the following:
 - Expansion and enhancement of Care Coordination and Emergency Mobile (EMS) service by \$3,000,000 and \$7,000,000, respectively
 - Emergency Mobile Services: Eleven (11) Emergency Mobile Service programs were fully implemented. These programs assist families during a psychiatric crisis of their youngster. The EMS programs are also available to provide crisis intervention at schools, upon authorization of a student's parent
 - Care Coordination: A total of sixty (60) Care Coordination positions exist in Connecticut to service children with multiple system involvement through the Community Collaboratives.
- Finalization of DCF Voluntary Services policy to provide services for children or youths requiring community-based treatment or temporary residential or other out of home placement who might otherwise be committed as neglected, uncared for, or dependent. This program is designed to encourage the preservation and enhancement of family relationships and the continuing rights and responsibilities of parents even though limited financial resources prevent them from providing the required care and treatment for their child.
- Implementation of contract boilerplates for Care Coordination, EMS, and Intensive In-home Services to better ensure consistent and uniform service delivery
- Service expansion funded by the Mental Health Strategy Board to create Flexible Funding to aid Systems of Care in creative and innovative service provision, implementation of Early Childhood Mental Health Consultation Services, and programming to provide early, school-based mental health intervention for children in grades K-12
- Forums held in each of DCF's region's to facilitate dialogue and increased linkage between the education system and the System of Care Community Collaboratives.
- DCF implemented the Strengthening Communities grant from the Center of Substance Abuse Treatment (CSAT) for the Hartford Youth project. This grant is for \$750,000 dollars per year, for five years. The project enhances the community-based treatment system through outreach, using

evidenced based treatment models of MST, Multi-Dimensional Family Therapy and Cognitive Behavioral and Motivational Enhancement Therapy.

- The Department is finalizing its contract and RFP policies. These policies have been updated to include language and expectations that are congruent with the tenets of KidCare and will support the provision of culturally appropriate services.
- In-Home Services- Each region has finalized contract negotiations and implemented Intensive In-Home Services. This service category, based upon evidence-based models, most notably Yale University's Intensive In-Home Child and Adolescent Program (IICAP's), will offer families the opportunity to receive clinical services in their home environment.
- Re-constitution of CBHAC Multiculturalism Committee- The CBHAC Multiculturalism Committee was reinitiated during SFY 2002. This Committee has identified federal funds to support regional, community initiatives through the Systems of Care to promote cultural competency.

BEST PRACTICES

Community Collaboratives continue to engage in creative practices to supplement the current service continuum for children with complex behavioral health needs and their families. The Status Report surveys reveal that the vast majority of Collaboratives have adopted activities that exemplify the best qualities of a community approach and interagency coordination. The Best Practices identified by the Community Collaboratives in SFY 2003 are as follows:

- Community Collaborative Recognition Breakfast
- Community Collaborative Open House
- Establishing a Community Collaborative Booth at community events
- Community Outreach, Informational and Legislative Breakfasts
- Creation of Community Collaborative subcommittees
- Posting of Community Collaborative times, dates and locations of meetings on FAVOR website
- Team building retreat for Collaborative members
- Use of non-traditional settings for Collaborative meetings (e.g., church, fire station)
- Use of membership dues to support flexible funding
- Development of standing agenda items for Community Resource Committee meetings (e.g., membership expansion, service utilization, needs, gaps, barriers to service, etc.)
- Development of Community Collaborative brochures (included bi-lingual)
- Identification of funds to engage in wraparound programming (e.g., funding camp for children with SED)
- Partnering with community stakeholders to better meet children and families' complex needs (e.g., business, churches, etc.)
- Organizing fundraising activities to support flexible funding
- Applying for Community Foundation Grants
- Applying for, receiving and implementing Connecticut Health Foundation Grant (multiple Collaboratives)
- Providing stipends to parents to aid in their participation in Community Collaboratives
- Creating specialized recreation programs for children with SED
- "Night with Legislators" involved local agency and Community Collaborative member parents
- Direct outreach to recruit new members and have "missing members" return
- Half and Full day workshops to develop individualized strategic plans that were outlined at the Statewide Community Collaborative Technical Assistance Workshop
- Establishment of a separate fund for non-Level III children who come to the attention of the collaborative; the fund was created through the involvement of clergy and church donations
- Presence of a "small but motivated group of parents"

- Began a parent support group in the area
- Ongoing diligence to achieve full compliance with the Practice Standards
- Excellent collaboration with local Board of Education and DCF on project
- Overall increase in the Community Resource Committee membership
- Made more use of therapeutic recreation and social support programs
- Flexible and discretionary funds were used to meet the needs of specific children and families
- Implemented and expanded EMS and Care Coordination programs
- Have provided ongoing support financially and emotionally to new support group for parents of children with autism
- Have a consistent, committed and regularly attending core group from a large variety of offices
- Have achieved more participation from parents and education personnel
- Developed a cultural competence committee
- Had Collaborative members participate in KidCare training
- Had a “Kick Off event” for a new collaborative and brought in speakers from 2 other collaboratives
- Collaborative member participate in a “work-out challenge” - funds raised were used for heat, food, clothing, etc. for families receiving services through the collaborative
- Creation of 2 sub-committees: one to serve Level I and II children and families and one to create a local resource map of available services
- Had two (2) Family Day Trips at Lake Compounce Amusement Park for all Local System of Care Families – Collaborative paid for all expenses
- Holiday party for families
- Annual meeting/picnic to bring together families, providers, leaders of various state/local foundations, legislators, Families United and AFCAMP
- Had donations from local businesses, faith-based institutions to pay for services for specific families and to develop ongoing fund
- Re-written mission statement and are developing yearly goals

The sentiment of many respondents regarding “Best Practices” was summed up nicely in the following:

“Our greatest success has been in the delivery of Care Coordination services to families who are struggling, especially by linking people to necessary services, helping them navigate ‘the system,’ providing support, being able to provide needed goods and services through a [DCF Regional Office] grant and through the excellent collaboration between our traditional and non-traditional providers.”

FUTURE DIRECTIONS/OVERCOMING BARRIERS

The areas of improvement for Collaborative Collaboratives continue to mature congruently with the evolution of these complex care systems. Last year’s Status Report indicated that some of the Collaboratives were still grappling with fundamental issues of Practice Standards compliance. These numbers have dropped again this year, but most Collaboratives report the desire to have on-going technical assistance about how they can best meet the expectations articulated under Connecticut’s System of Care model. As KidCare continues to evolve and be implemented, the duties and responsibilities of the various tiers of the Community Collaborative will be more clearly defined.

There were a number of consistent themes presented in the Status Report Surveys that spoke to the barriers and challenges the Collaboratives are facing. Some of the areas identified as requiring further exploration and explication are as follows:

- Defining Community Collaborative membership versus participation
- Supporting greater Parent involvement at all levels of the system
- Ensuring consistent attendance at the CRC level

- Increasing the commitment levels of members to practice in new and creative ways
- Facilitating greater Collaborative membership by non-traditional providers (e.g., housing, community-action agencies, and early childhood agencies.)
- Operationally defining and implementing elements of the Practice Standards
- Creating sustainable cultural competence agendas

Additional guidance around key aspects of effective Community Collaboration must occur. Future directions for the Community Collaboratives include the following:

- **Bylaws:** The existence of bylaws individualized for each Collaborative might be beneficial. These bylaws could address important standard areas such as membership, attendance, voting, Request For Proposal (RFP) application and support. The issue of membership (rather than participation) is particularly critical as it impacts much of the work and function of the Community Collaboratives. Discussions with collaborative members and responses on the survey indicate that the concept of membership and participation are interchangeable for some Collaboratives. While this issue may seem to be one of semantics, it is concretely important for Collaboratives to solidify an operational definition for membership. The difference is most critical in situations where an RFP requires an applicant agency to be a member of the local Collaborative. This is also of impact where voting on issues is required. Without a concrete definition of membership, participation as team members only when a specific decision-making matter is presented can potentially divert the will of a Collaborative.
- **Annual Work Plans:** As a result of the Technical Assistance Workshops held this past year, each Community Collaborative that attended has created or is in the process of creating a strategic work plan. These plans will help the Collaboratives define their priorities and activities for the coming year, guide the work of their subcommittees and measure their achievements.
- **Annual needs assessments:** The localized nature of the Community Collaboratives positions them to engage in critical needs assessments. Using the multiple perspectives and linkages that exist from the collaborative's membership, these consortiums seem best able to collect and analyze community level data about service barriers, gaps and needs, especially with respect to the availability and delivery of services that are Culturally Competent.
- **Core Agenda:** The establishment of standing, core agenda items was identified as being constructive in assisting the Collaboratives with their duties. Those Collaboratives that have set agenda items seem to have more active CRC's and CRC subcommittees and use these updates to inform the activities in which they engage. It may be beneficial for all Collaboratives at the CRC level to ensure that updates on Care Coordination utilization, referrals, aggregated demographic information, waitlist, key service availability (e.g., Extended Day Treatment, Respite, In Home services, Family Advocacy and EMS) regularly occur.
- **Community Collaborative Certification.** This suggestion will continue to require much further discussion and refinement. The system must have a clear means of determining the community entities that will be allowed to have a formal nexus with the KidCare administrative service organization. The concept of certifying Collaboratives to have such a formal recognition is being considered. The specific elements of a Community Collaborative certification would need to be fleshed out. Certainly, the CBHAC would need to be integrally involved in this matter.
- **Leadership:** Formal and informal leadership of the Collaboratives has perennially been identified as a challenge facing some Community Collaboratives. The issue continues to generate diverse opinions about how the collaboratives should be facilitated and by whom. Overall, respondents were pleased that leadership structures emerged over the past year resulting in meetings being more productive and

structured. The development of bylaws that address membership, roles, referral prioritization, data dissemination and chairmanship, might assist with resolving this issue. The institution of a practice of identifying parents to serve as Collaborative chairs and co-chairs has been encouraged and supported through the department and by external consultants; more work needs to be focused in this area to achieve more balance in the direction and composition of these teams.

- Collaborative Support Positions: Due to the large number of Community Collaboratives, and the increasing labor-intensive work of these bodies, dedicated staff positions would be beneficial. These positions would be responsible for assisting the Collaboratives with the development of annual work plans, organizing and coordinating Community Collaborative outreach efforts, serving as staff to Collaborative subcommittees, and leading fundraising endeavors (e.g., grant-writing).
- Peer Technical Assistance and Cross-Collaborative Team Building: Opportunities for all members of the local Collaboratives to meet, network and share information are not routinely available. Regular occasions where the Collaboratives can meet to exchange best practices and receive technical assistance from one another are important learning and team building opportunities.
- Peer and Self-Fidelity Assessment: Through peer and self-assessment, utilizing agreed upon indicators, each Collaborative could be evaluated to determine their level of fidelity to the principles and values of the System of Care approach. This type of assessment would assist the collaboratives in the development and implementation of their annual strategic work plans.
- Social Marketing Plan: Many Collaboratives report difficulty attracting and sustaining participation from non-traditional service organizations, especially providers of recreational programming. Respondents noted that non-traditional providers attend a handful of meetings, but often stop participating due to a lack of clarity regarding how they can contribute to, and gain from, the collaborative process. Developing strategic material targeted to non-traditional entities (e.g., community agencies, businesses, churches, etc.) specifically addressing the concerns of these entities, may secure broader membership in the Collaboratives. A formal social marketing plan would also assist Collaboratives with having prepared brochures and other material that explain this community initiative to potential funding sources (e.g., foundations and charitable organizations).

SUMMARY

Information gathered throughout this past year and through the survey responses indicate that Department efforts could focus on the following areas:

1. Providing the Collaboratives with information and technical assistance to develop social marketing plans. This is a requirement of the federally funded PARK Project and work generated in that sphere can be adapted to the unique needs of the state's 27 Collaboratives.
2. Providing a presence at local Collaborative meetings to reinforce and encourage the membership of diverse groups of people from all segments of the community. Attention must be paid to "bridging the gap" that can occur between the CRC and CST. When asked why they attend their local collaborative meetings, many respondents indicated the desire to provide good community based care for children and strong beliefs the System of Care philosophy. Membership will be more attractive to a wider array of service providers, the business community and other parents if current collaborative members can clearly explain to prospective members how their participation can make a difference in the quality of life for a child and family at the CST level, the community in general and the families who reside in it.

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Appendix I

Service Effectiveness Coordinators (or their designee) should oversee the collection of data and completion of this and the next page. Complete and submit the remainder of the survey only if you represent your agency as a collaborative member. (Complete these 2 pages once per collaborative).

Please attach a copy of the strategic plan that was generated through the collaboratives participation in the Technical Assistance Workshops on May 15 & 16 or June 5 & 6.

Provide a completed copy of these two pages to your collaborative to help facilitate their responses.

Name of Collaborative:

Towns Served:

1. How many total referrals (including those not accepted) for Care Coordination were received from July 1, 2002 to June 30, 2003:

2. Does the collaborative have agreements in place with respect to participation in the collaborative (e.g., Memorandum of Agreement/Understanding, etc.)? If "Yes," please attach a blank, sample copy, if available.

☐ Yes ☐ No

3. How does this Community Collaborative define "membership?"

a. Total number of members in the collaborative or on the Community Resource Committee (CRC):

b. Of the total number, how many are Parents/Care Givers:

c. Of the total number, how many are Non-Traditional Providers:

Please list the types of non-traditional services to which your collaborative has access. Indicate which services families utilized as a result of Child Specific Team Meetings. (Attach additional pages, if needed.)

d. Of the total number, how many are Traditional Service Providers:

Please list the types of traditional services to which your collaborative has access. Indicate which services families utilized as a result of Child Specific Team Meetings. (Attach additional pages, if needed.)

e. Are any of the following services/providers members of or represented on the CRC? (Check all that apply)

☐ Education ☐ Early Childhood Development Programs ☐ Adolescent Substance Abuse Providers

☐ Housing Providers ☐ Adult Mental Health Treatment Providers ☐ Adult Substance Abuse Treatment Providers

☐ Substance Abuse Prevention Services ☐ Pediatricians ☐ Other Physicians ☐ Youth Service Bureaus

☐ Managed Medicaid Companies ☐ Private Insurance Companies ☐ Local Law Enforcement ☐ Hospital(s)

☐ Local Civic Groups (Lions, Elks, Rotary, etc.) ☐ Local Businesses ☐ Local Banks ☐ Day Care Facilities

☐ Recreation ☐ Private Funding Foundations ☐ Dep't of Social Services (DSS) ☐ Juvenile Justice (CSSD)

☐ Dep't of Mental Retardation (DMR) ☐ Dep't of Mental Health & Addiction Services (DMHAS) ☐ Clergy

☐ Other Local Municipal Agency: _____

☐ Other State Agency: _____

☐ Other Prevention Services: _____

☐ Other Services: _____

f. If you indicated that Education is a member of your collaborative, please complete the following:

(1) Please identify the school system(s) that are members of the CRC and their representative(s) (i.e. - teacher, social worker, principal, etc., not actual identities) at the CRC meetings:

(2) Please identify school systems that have participated in individual Child Specific Team (CST) meetings:

(3) Please identify school systems that have participated in CST meetings even if not a formal member of this Community Collaborative:

4. Please identify any sub-committees of the collaborative.

A minimum of 6 collaborative members should complete the following pages either in a group format or individually. Respondents should include (but not be limited to) a chairperson, parent(s), non-traditional and traditional service providers, and a care coordinator. *Please type or print all responses.*

Name of Collaborative:

Please describe your affiliation to the collaborative (agency rep., parent, clergy, etc.) and the role you fulfill in the collaborative. If the completion of this form was a group effort, please identify the roles and numbers of those who participated (i.e. – 3 parents, 2 clergy, 1 therapist, etc.).

1. Please identify any efforts in which the collaborative has engaged to recruit and maintain membership of parents/caregivers. (Attach additional pages, if needed.)

2. Who is not represented at this collaborative that you believe should be (i.e. - traditional/non-traditional service providers, clergy, businesses, parents, state agencies, etc.)? What specific recruitment efforts have been utilized to engage these groups? If recruitment efforts have not been made, please explain why. (Attach additional pages, if needed.)

3. On a scale of 1-10, with 10 being the best, please rate the following items. (Attach additional pages, if needed.)

The quality of the relationship between parents and traditional (clinical or therapeutic) service providers.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

The quality of the relationship between parents and non-traditional (non-clinical or therapeutic) service providers.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

The quality of the relationship between non-traditional (non-clinical) and traditional (clinical or therapeutic) service providers.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

The quality of the relationship between the collaborative (as a whole) and the community it serves.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

The quality of the relationship between the collaborative and The Department of Children and Families.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

4. On a scale of 1-10, with 10 being the best, please rate the cultural competence of the collaborative as a whole.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

Please detail the activities in which the collaborative has engaged to promote cultural competence. (Attach additional pages, if needed.)

5. Please identify the training needs of the Collaborative and the community it serves.

6. On a scale of 1-10, with 10 being the best, please rate the overall functioning of the collaborative.

1 2 3 4 5 6 7 8 9 10

In your opinion, what would need to happen to move up at least one number on the scale?

Please identify any other changes and/or modifications to the collaborative and/or the larger System of Care you think should occur that would improve the overall functioning of the collaborative (i.e. - decision-making, diverse representation, more focus, specific activities, etc.). If you attended the Technical Assistance Workshop in May or June, please share the ideas and/or recommendations for collaborative building that were presented and/or developed that you would like to see implemented. (Attach additional pages, if needed.)

7. Please list some of the reasons you as an individual participate in the Community Collaborative. If using group format, please include individual responses from your participants. (Attach additional pages, if needed.)

8. Please identify the challenges, issues, or barriers that your collaborative faced in the past year. What solutions were generated to address these? Were the outcomes successful? If not, what do you think prevented success? Describe what community resources were needed but not available in the past year that would have been helpful dealing with identified needs.

9. Please identify any practices in which your collaborative engaged that you feel were exemplary during the past year (e.g., funding generated, service development, extraordinary activities, ideal collaboration and accomplishments.) *Please be specific by detailing the identified exemplary practice(s).* (Attach additional pages, if needed):

Please return the survey by **AUGUST 22, 2003** to:

Kurt Fuchs
Department of Children and Families
Division of Mental Health
505 Hudson Street
Hartford, CT 06106

Responses can also be returned via e-mail to kurt.fuchs@po.state.ct.us or fax at 860-566-8022. An electronic copy of this survey can be obtained by contacting me via e-mail at the above address.

Appendix II

Table 5. Existing Community Collaboratives by Region

Region	Collaborative	Towns
W	Greater Norwalk System of Care/CARE Team	Norwalk, Westport, Weston, and Wilton
W	Stamford System of Care Collaborative/CPR	Stamford, Greenwich, Darien, and New Canaan
W	Greater Bridgeport System of Care Collaborative	Bridgeport, Trumbull, Fairfield, Monroe and Easton
W	Stratford System of Care	Stratford
S	Lower Naugatuck Valley Collaborative	Ansonia, Derby, Seymour and Shelton
S	Family Access- Eastern Middlesex Collaborative	Portland, East Haddam and East Hampton
S	Valley Shore Collaborative	Chester, Clinton, Deep River, Essex, Lyme, Old Lyme, Old Saybrook and Westbrook
S	Middlesex System of Care	Middletown, Cromwell, Durham and Middlefield
S	Shoreline Collaborative	East Haven, Branford, North Branford, Guilford, Madison, Clinton, Higganum and Killingworth
S	Hamden/North Haven Collaborative	Hamden and North Haven
S	West Haven Collaborative	West Haven
S	BOWA (Bethany Orange Woodbridge Amity Collaborative)	Bethany, Orange, Woodbridge and Amity
S	Meriden/Wallingford Collaborative	Meriden and Wallingford
S	Milford Collaborative	Milford
S	New Haven Collaborative	New Haven
S	South Eastern Mental Health System of Care	Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Westbrook Ledyard, Lisbon, Lyme, Montville, New London, Stonington, N. Stonington Norwich, Preston, Salem, Sprague, Voluntown, Waterford
N	Communities Raising Children	Ashford, Brooklyn, Canterbury, Chaplin, East ford, Hampton, Killingly, Pomfret, Putnam, Scotland, Sterling, Thompson, Windham, Woodstock, Columbia Coventry, Union, Willington
N	North Central System of Care	Enfield, Somers, Stafford Springs, East Windsor, Granby, East Granby, Suffield, Windsor Locks Bloomfield, Windsor
N	New Britain System Collaborative	New Britain
N	Hartford/West Hart Collaborative	Hartford and West Hartford
N	Bristol Collaborative	Bristol
N	East of the River Collaborative	Manchester, Vernon, Tolland, Ellington, South Windsor, Bolton,
N	Route 2 Community Collaboration	East Hartford, Glastonbury, Hebron, Andover, Marlborough
W	Waterbury Children's Action Council	Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Oakville, Oxford, Prospect, Roxbury, Southbury, Waterbury Watertown, Washington, Wolcott, Woodbury
N	Rocky Hill, Newington & Wethersfield Collaborative	Rocky Hill, Newington, Wethersfield, Kensington & Berlin
W	Danbury System of Care Collaborative	Danbury, Redding, Ridgefield, New Milford, Bethel, Newtown, New Fairfield, Sherman, Bridgewater, Brookfield
W	North West Corner System of Care	Torrington, Salisbury, North Canaan, Norfolk, Colebrook, Hartland, Winchester, Oxford Barkhamstead, New Hartford, Goshen, Cornwall, Sharon, Kent, Warren, Litchfield, Morris, Harwinton Burlington, Thomaston